SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: CovOne (Individual) Product	SERFF Tr Num: CVKS-126855093	State: Arkansas
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 47022
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Jennifer Simms	Disposition Date: 01/13/2011
	Date Submitted: 10/11/2010	Disposition Status: Approved-Closed
Implementation Date Requested: 01/01/2011		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/13/2011
	State Status Changed: 01/13/2011
Deemer Date:	Created By: Jennifer Simms
Submitted By: Jennifer Simms	Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Policy, et al for approval. New product filing.

Company and Contact

Filing Contact Information

Jennifer Simms, Regulatory Compliance	jesimms@cvty.com

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Analyst
8320 Ward Parkway
Kansas City, MO 64114
866-795-3995 [Phone] 4539 [Ext]
816-460-4695 [FAX]

Filing Company Information

Coventry Health and Life Insurance Company	CoCode: 81973	State of Domicile: Delaware
8320 Ward Parkway	Group Code: 1137	Company Type: LAH
Kansas City, MO 64114	Group Name: Coventry Health Care	State ID Number:
(866) 795-3995 ext. 4539[Phone]	FEIN Number: 75-1296086	

Filing Fees

Fee Required?	Yes
Fee Amount:	$550.00
Retaliatory?	No
Fee Explanation:	10 Forms + 1 Rate filing @ $50 each = $550
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Company	$550.00	10/11/2010	40578972

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/13/2011	01/13/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	11/09/2010	11/09/2010	Jennifer Simms	11/11/2010	11/11/2010
Pending Industry Response	Rosalind Minor	10/22/2010	10/22/2010	Jennifer Simms	10/27/2010	10/27/2010
Pending Industry Response	Rosalind Minor	10/22/2010	10/22/2010	Jennifer Simms	10/26/2010	10/26/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Individual Policy	Jennifer Simms	12/16/2010	12/16/2010
Supporting Document	Redline COC 2010 12 16	Jennifer Simms	12/16/2010	12/16/2010
Rate	2011 01 01	Jennifer Simms	10/28/2010	10/28/2010

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Consent to Extension & Question	Note To Reviewer	Jennifer Simms	12/13/2010	12/13/2010
Extension of Review	Note To Filer	Rosalind Minor	12/08/2010	12/08/2010
Your Response to my Objection Letter on 11/11/2010`	Note To Filer	Rosalind Minor	11/12/2010	11/12/2010
Deemer Waiver	Note To Reviewer	Jennifer Simms	11/08/2010	11/08/2010
Deemer	Note To Filer	Rosalind Minor	11/08/2010	11/08/2010

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/13/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Supporting Document	Coverletter with Statement of Variability	Approved	Yes
Supporting Document	Redline COC/SOB 2010 10 26	Approved	Yes
Supporting Document	Redline COC 2010 12 16	Approved	Yes
Form *(revised)*	Individual Policy	Approved	Yes
Form	Individual Policy	Replaced	Yes
Form	Individual Policy	Replaced	Yes
Form	Pharmacy Rider	Approved	Yes
Form *(revised)*	Schedule of Benefits	Approved	Yes
Form	Schedule of Benefits	Replaced	Yes
Form	Exclusion Rider	Approved	Yes
Form	TMJ Rider	Approved	Yes
Form	Mental Health Substance Abuse Rider	Approved	Yes
Form	Hearing Aid Rider	Approved	Yes
Form	Application for Coverage	Approved	Yes
Form	Change Form/application	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Rate *(revised)*	2011 01 01	Approved	Yes
Rate	2011 01 01	Replaced	Yes
Rate	2011 01 01	Replaced	Yes

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/09/2010
Submitted Date	11/09/2010
Respond By Date	

Dear Jennifer Simms,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Policy, CHL-AR-COC-001-10.10 (Form)

Comment:

Upon further review of the policy, I could not find a statement that complies with Rule and Regulation 18, Section 7 A (15).

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/11/2010
Submitted Date	11/11/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: Upon review of "Rule 18, Section 7. Disability Minimum Standards for Benefits, A. General Rules, (15) Termination of the Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period the Policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits." Coventry respectfully requests further clairification. This Rule addresses Disabiltiy benefits of Individual Policies. The Policy intended for use in Arkansas does not provide Disabiltiy benefits. As such, a termination provisions in accordance with this Rule is not applicable. The disability of an individual is not deemed a termination event under this policy.

Related Objection 1

Applies To:

- Individual Policy, CHL-AR-COC-001-10.10 (Form)

Comment:

Upon further review of the policy, I could not find a statement that complies with Rule and Regulation 18, Section 7 A (15).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your attention to this filing; it is very much appreciated.

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Sincerely,
Jennifer Simms

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/22/2010
Submitted Date	10/22/2010
Respond By Date	

Dear Jennifer Simms,

This will acknowledge receipt of the captioned filing.

Objection 1

- Coverletter with Statement of Variability (Supporting Document)
- 2011 01 01, [] (Rate)

Comment:

Your cover letter states that Coventry certifies that the out of network differential will be no more than 25% greater than the in-network cost share.

However, when reviewing Attachment 1 to the Actuarial Memorandum, Plans D, E, F & G, Preventive Health, there is a 100% benefit for In Network and 60% for out of network which is greater than 25%. Please explain how these percentages are in compliance with out Bulletin 9-85.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/27/2010
Submitted Date	10/27/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: Rate Attachment updated; oversight by the Actuary.

Related Objection 1

Applies To:

- 2011 01 01, [] (Rate)
- Coverletter with Statement of Variability (Supporting Document)

Comment:

Your cover letter states that Coventry certifies that the out of network differential will be no more than 25% greater than the in-network cost share.

However, when reviewing Attachment 1 to the Actuarial Memorandum, Plans D, E, F & G, Preventive Health, there is a 100% benefit for In Network and 60% for out of network which is greater than 25%. Please explain how these percentages are in compliance with out Bulletin 9-85.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
2011 01 01		*New*	*Previous State Filing Number* *0*	

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Previous Version

2011 01 01 *Other*

Previous State Filing Number

Rate Action Other Explanation

0

Sincerely,
Jennifer Simms

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/22/2010
Submitted Date	10/22/2010
Respond By Date	11/22/2010

Dear Jennifer Simms,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Policy, CHL-AR-COC-001-10.10 (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Objection 2

- Schedule of Benefits, CHL-AR-SOB-003-10.10 (Form)

Comment: The schedule of benefits states that organ transplates are covered/provided at an approved Coventry Transplant only. This would be considered an EPO, Exclusive Provider Organization, which is not allowed in Arkansas.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/26/2010
Submitted Date	10/26/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: Language added, per your Objection.

Related Objection 1

Applies To:

- Individual Policy, CHL-AR-COC-001-10.10 (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Redline COC/SOB 2010 10 26

Comment: Redline document to identify changes per your Objections, for your convenience.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Individual Policy	*CHL-AR-COC-001-10.10*		*Policy/Contract/Fraternal Certificate*	*Initial*		*40.000*	CHL-AR-COC-001-10.10.pdf
Previous Version							
Individual Policy	*CHL-AR-*		*Policy/Contract/Fraternal*	*Initial*		*40.000*	CHL-AR-

COC-001-10.10	*Certificate*	COC-001-10.10.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: Language revised, per your Objection.

Related Objection 1

Applies To:

- Schedule of Benefits, CHL-AR-SOB-003-10.10 (Form)

Comment:

The schedule of benefits states that organ transplates are covered/provided at an approved Coventry Transplant only. This would be considered an EPO, Exclusive Provider Organization, which is not allowed in Arkansas.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Redline COC/SOB 2010 10 26

Comment: Redline document to identify changes per your Objections, for your convenience.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Schedule of Benefits	CHL-AR-SOB-003-10.10		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial			CHL-AR-SOB-003-10.10.pdf
Previous Version							
Schedule of Benefits	*CHL-AR-SOB-003-10.10*		*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*			CHL-AR-SOB-003-10.10.pdf

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

No Rate/Rule Schedule items changed.

Thank you for reviewing this filing so quickly; your attention and response is very much appreciated.

Sincerely,
Jennifer Simms

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 12/16/2010

Comments:

Update for Rule 18, Section 7 (A) 15 - see Form tab (COC) and Supporting documentation tab (Redline COC 2010 12 16). The Discontinuation of Coverage provision was updated to include this rule based on Mr. Honey's latest email explaining intent and application of the Rule.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
CHL-AR-COC-001-10.10	Policy/Contract/Fraternal Certificate	Individual Policy	Initial				40.000	CHL-AR-COC-001-10.10.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Redline COC 2010 12 16

Comment:

COC Redline 2010 12 16.pdf

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Jennifer Simms on 12/13/2010 10:35 AM

Last Edited By:

Rosalind Minor

Submitted On:

01/13/2011 01:44 PM

Subject:

Consent to Extension & Question

Comments:

Thank you for the note on the extension for actuarial review. Additionally, have you received any directive regarding my latest email on 12/8/10 from Dan & Booth regarding Rule 18, Section 7 (A) 15?

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Note To Filer

Created By:
Rosalind Minor on 12/08/2010 10:51 AM
Last Edited By:
Rosalind Minor
Submitted On:
01/13/2011 01:44 PM
Subject:
Extension of Review
Comments:
We appreciate your patience with our Department's review of your submission.

We are extending the time for review past the Deemer Date because we need a little extra time to consult with our Actuary. As always, we appreciate your understanding and cooperation.

May your holidays be happy and safe.

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Note To Filer

Created By:
Rosalind Minor on 11/12/2010 11:38 AM
Last Edited By:
Rosalind Minor
Submitted On:
01/13/2011 01:44 PM
Subject:
Your Response to my Objection Letter on 11/11/2010`
Comments:
You state in your comments that the Rule addresses Disability Benefits of Individual Policies. Act 1603 of 2001 amended various chapter and sub-chapters of the Arkansas Insurance Department Code in order to replace the term "Disabillity" Insurance with the term "Accident and Health insurance, where warranted and appropriate. Section 7 , Disability Minimum Standards for Benefits should now read: Accident and Health Minimum Standards for Benefits.

In this case, under Section 7 A(15), if an insured has, prior to the effective date of termination or non-renewal, been diagnosed and treated for a sickness or injury which is compensable under the policy, benefits directly related to that sickness or injury may continue in accordance with the policy limitations for so long as that insured is being treated under a continuous plan of treatment by a physician for that sickness or injury. However, unrelated problems would not be covered.

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:
Jennifer Simms on 11/08/2010 01:50 PM
Last Edited By:
Rosalind Minor
Submitted On:
01/13/2011 01:44 PM
Subject:
Deemer Waiver
Comments:
I, Jennifer Simms, representing Coventry Health & Life Insurance Company, do hereby

acknowledge receipt of this letter and waive all rights to deemer on this filing.

Jennifer Simms, Regulatory Compliance Analyst 11/8/10
Dated Signature and Title

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Note To Filer

Created By:
Rosalind Minor on 11/08/2010 11:13 AM
Last Edited By:
Rosalind Minor
Submitted On:
01/13/2011 01:44 PM
Subject:
Deemer
Comments:

Thank you for the additional information which you provided on this filing which was submitted to our Department on October 11, 2010.

Pursuant to the provisions of Ark. Code Ann. 23-79-109(b), the period for review of this filling is being automatically extended an additional thirty (30) days until December 11, 2010.

We request that you sign and return this form letter in order to waive all rights to deemer on this filing.

Sincerely,

Rosalind D. Minor
Compliance Officer
Life and Health Division

RDM

I,_____, representing_____, do hereby

acknowledge receipt of this letter and waive all rights to deemer on this filing.

_____, _____

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Dated Signature and Title

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 10/28/2010

Comments:

Correction to Revised document - and updated document to be OCR compliant.

Changed Items:

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
2011 01 01 2011 01 01 (Rev 2).pdf		New		2011 01 01 (Rev 2).pdf

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: CHL-AR-COC-001-10.10

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/13/2011	CHL-AR-COC-001-10.10	Policy/Contract/Fraternal Certificate	Individual Policy	Initial		40.000	CHL-AR-COC-001-10.10.pdf
Approved 01/13/2011	CHL-AR-RID-002-10.10	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Pharmacy Rider	Initial		40.000	CHL-AR-RID-002-10.10.pdf
Approved 01/13/2011	CHL-AR-SOB-003-10.10	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Schedule of Benefits	Initial			CHL-AR-SOB-003-10.10.pdf
Approved 01/13/2011	CHL-AR-RID-004-10.10	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorseme	Exclusion Rider	Initial		40.000	CHL-AR-RID-004-10.10.pdf

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Approved 01/13/2011	CHL-AR-RID-005-10.10	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	TMJ Rider	Initial	40.000	CHL-AR-RID-005-10.10.pdf
Approved 01/13/2011	CHL-AR-RID-006-10.10	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Mental Health Substance Abuse Rider	Initial	40.000	CHL-AR-RID-006-10.10.pdf
Approved 01/13/2011	CHL-AR-RID-010-10.10	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Hearing Aid Rider	Initial	40.000	CHL-AR-RID-010-10.10.pdf
Approved 01/13/2011	CHL-AR-APP-007-10.10	Application/Enrollment Form	Application for Coverage	Initial		CHL-AR-APP-007-10.10.pdf
Approved 01/13/2011	CHL-AR-APP-008-10.10	Application/Enrollment Form	Change Form/application	Initial		CHL-AR-APP-008-10.10.pdf
Approved 01/13/2011	CHL-AR-OOC-009-10.10	Outline of Coverage	Outline of Coverage	Initial	40.000	CHL-AR-OOC-009-10.10.pdf

Health Care Benefits

Arkansas

PREFERRED PROVIDER ORGANIZATION ("PPO")

INDIVIDUAL POLICY

IMPORTANT NOTICE

THIS POLICY, THE APPLICATION AGREEMENT AND ALL ATTACHED RIDERS SHOULD BE READ IN THEIR ENTIRETY.

Carefully check the application agreement and write to Coventry Health & Life Insurance Company at the address listed below, within ten (10) days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application agreement. This application agreement is part of the Policy and the Policy was issued on the basis that answers to all questions and the information shown on the application agreement are correct and complete. You may return this Policy within ten (10) days of its receipt for a full refund of any Premiums paid if, after examining it, You are not satisfied for any reason.

The Insured has the full freedom of choice in the selection of any duly licensed health care professional. This Policy has provisions reducing the amount of Coverage the Insured receives depending on which Physicians or other health care providers are used. Please consult this Policy, the Schedule of Benefits and Provider Directory for more details. If you have any additional questions, please write or call us at:

Coventry Health & Life Insurance Company
[8320 Ward Parkway]
[Kansas City, MO 64114]
[(800) 969-3343]
[www.chckansas.com]

Welcome to Coventry Health & Life Insurance Company!

We are extremely pleased to have You enrolling in our Plan and look forward to serving You. We have built a strong network of area Physicians, Hospitals, and other providers to offer a broad range of services for Your medical needs.

As a Coventry Health & Life Insurance Company Insured, it is important that You understand the way Your Plan operates. This Policy contains the information You need to know about Your Coverage with us.

Please take a few minutes to read these materials so that You are aware of the provisions of Your Coverage. Our Customer Service Department is available to answer any questions You may have about Your Coverage. You can reach them at the number listed in the Schedule of Important Numbers Monday through Thursday, 8:00 a.m. to 6:00 p.m., Friday, 8:00 a.m. to 5:00 p.m. Central Standard Time. You can also check the Plan's website at www.chckansas.com any time for additional information.

We look forward to serving You.

Sincerely,

[Michael Murphy]

Chief Executive Officer

This Policy is guaranteed renewable to age 65 or eligibility for Medicare subject to the termination provisions in Eligibility & Termination. Premium rates may be changed on a class basis.

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Coventry Health & Life Insurance Company
Individual Policy

The Policy between **Coventry Health & Life Insurance Company** (hereafter called the "Plan") and You is made up of:

- This Policy and Amendments;
- Application Form;
- Applicable Riders;
- Provider Directory; and
- Schedule of Benefits.

No person or entity has any authority to waive any Policy provision or to make any changes or Amendments to this Policy unless approved in writing by an Officer of the Plan, and the resulting waiver, change, or Amendment is attached to the Policy. This Policy begins on the date defined in the proposal rate acceptance, and continues until replaced, or terminated. You are subject to all terms, conditions, limitations, and exclusions in this Policy and to all the rules and regulations of the Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of this Policy.

THE POLICY SHOULD BE READ IN ITS ENTIRETY. By carefully reading this Policy and understanding Your relationship to the Plan, You can be an informed participant. You should keep this Policy in a safe place for Your future reference. Many of the provisions of this Policy are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Policy will appear capitalized because they have special meaning and are defined for You. By using these definitions, You will have a clearer understanding of Your Coverage. From time to time, the Policy may be amended. When that occurs, the Plan will provide an Amendment or a new Policy to You.

The Plan is responsible for making benefit determinations in accordance with this Policy and the Plan's agreements with Participating Providers. The Plan does not and will not make medical treatment decisions. Only Providers may make such decisions after meeting with You. If the Plan denies a claim for payment or Pre-Certification of a recommended service, You may request reconsideration of that decision through the Plan's Complaint and Grievance Procedure described in this Policy.

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Definitions

Any capitalized terms listed shall have the meaning set forth below whenever the capitalized term is used in this Policy.

"Activities of Daily Living"

Activities you usually do during a normal day including but not limited to bathing, dressing, eating, maintaining continence, toileting, transferring from bed to chair, and mobility.

"Acute"

Refers to an Illness or Injury that is both severe and of recent onset.

"Administrative Appeal"

An Appeal of a decision that has not been issued for medical necessity or medical appropriateness, but is administrative in nature, for example, appealing a Copayment, Coinsurance, or exclusion associated with a Covered Service.

"Adverse Benefit Determination"

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination may be based in whole or in part on a medical judgment and may also include:

- Any reduction or termination of a benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to not be Medically Necessary or medically appropriate;
- The failure to cover services because they are cosmetic;
- The failure, reduction, or termination regarding the availability and/or delivery of health care services;
- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services; and/or
- The failure, reduction, or termination regarding terms of the contractual relationship between Insured and the Plan.

"Alternate Facility"

A duly-licensed non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received, including without limitation:

- Scheduled surgical services;
- Emergency services;
- Urgent Care Services;
- Prescheduled rehabilitative services;
- Laboratory or diagnostic services;
- Inpatient or outpatient Mental Illness services or Substance Abuse services.

"Amendment"

Any attached written description of additional or alternative provisions to the Policy and/or this Policy. Amendments are effective only when Authorized in writing by the Plan and are subject to

all conditions, limitations and exclusions of the Policy except for those which are specifically amended.

"Ancillary Provider"

A Provider who is not licensed as a Physician or a Hospital.

"Appeal"

An Appeal is a request by You or Your Authorized Representative for consideration of an Adverse Benefit Determination of a service request or benefit that You believe You are entitled to receive.

"Authorized Representative"

An Authorized Representative is an individual authorized in writing or verbally by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for Health Insurance Portability and Accountability Act ("HIPAA") privacy purposes.

"Benefit Maximum"

A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for the Insured in any one Benefit Year. Once a Benefit Maximum is met, no more Covered Services will be provided during the same Benefit Year.

"Benefit Year"

The period of time during which the total amount of annual benefits under Your Coverage is calculated. Your policy may be issued on either a Calendar Year or Contract Year. Please call the customer service number on the back of your ID card to obtain information about Your Benefit Year.

"Calendar Year"

The period of time from January 1 through December 31 inclusive. This is the period during which the total amount of annual benefits under Your Coverage is calculated.

"Chronic Condition"

A health condition that is continuous or persistent over an extended period of time.

"Coinsurance"

Cost-sharing arrangement in which the Insured pays a specified percentage of the cost for a Covered Service.

"Coinsurance Maximum"

The annual limit of a Insured's coinsurance payments for Covered Services, as specified in the Schedule of Benefits"

"Complaint"

Any dissatisfaction expressed by You or Your Authorized Representative regarding a Plan issue.

"Confinement" and "Confined"

An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.

"Contract Year"

The period during which the total amount of yearly benefits under Your Coverage is calculated. The Contract Year is the period of twelve (12) consecutive months commencing on the Effective

Date and each subsequent anniversary.

"Copayment"

Cost-sharing arrangement in which the Insured pays a specified dollar amount as their share of the cost for a Covered Service.

"Cosmetic Services and Surgery"

Services performed to reshape structures of the body in order to alter appearance, to alter the aging process, or when performed primarily for psychological purposes. Cosmetic Services are not needed to correct or substantially improve a bodily function.

"Coverage" or "Covered"

The entitlement by the Insured to Covered Services under this Policy, subject to the terms, conditions, limitations and exclusions of the Policy, including the following conditions: (a) services must be provided when this Policy is in effect; and (b) services must be provided prior to the date that any of the termination conditions listed in this Policy occur; and (c) services must be provided only when the recipient is the Insured and meets all eligibility requirements specified in this Policy; and (d) services must be Medically Necessary.

"Covered Services"

The services or supplies provided to You for which the Plan will make payment, as described in the Policy.

"Custodial Care"

Care is considered custodial when it is primarily for the purpose of helping the Insured with Activities of Daily Living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. This term includes such other care that is provided to the Insured who, in the opinion of the Medical Director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized Insured, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to, respite care and home care which is or which could be provided by family members or private duty caregivers.

"Deductible"

The dollar amount of medical expenses for Covered Services that You are responsible for paying annually before benefits subject to the Deductible are payable under this Policy.

"Dental Services"

Services primarily for the prevention, diagnosis and treatment of diseases and injuries to the oral cavity, the teeth, and their surrounding structures.

"Dependent"

Any member of an Insured's family who meets the eligibility requirements and who is properly enrolled for Coverage under the Agreement and on whose behalf Premiums are paid.

"Designated Transplant Network Facility"

A Hospital appointed as a Designated Transplant Network Facility by the Plan, to render Medically Necessary and medically appropriate services for Covered transplants. You may request a listing that may be amended from time to time, of Designated Transplant Network Facilities from the Customer Service Department listed in the Schedule of Important Numbers.

"Designated Transplant Network Physician"

A Physician appointed as a Designated Transplant Network Physician by the Plan, who has entered into an agreement with a Designated Transplant Network Facility to render Medically

Necessary and medically appropriate services for Covered transplants.

"Durable Medical Equipment"

Medical equipment Covered under this Policy or attached Rider, which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an Illness or Injury, and is appropriate for use in the home. Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of Durable Medical Equipment will be considered Durable Medical Equipment.

"Elective Abortion"

An abortion for any reason other than a spontaneous abortion or to prevent the death of the Insured upon whom the abortion is performed.

"Eligible Expenses"

Charges for Covered Services, incurred while the Policy is in effect.

"Emergency Medical Condition" and "Medical Emergency"

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing the Insured's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part; or
- Inadequately controlled pain.

Some examples of an Emergency Medical Condition include, but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing; or
- Vaginal bleeding during pregnancy.

The Insured may seek medical attention from a Hospital, Physician's office or some other Emergency facility.

"Emergency Services"

Generally, Eligible Expenses for Emergency Services are the charges for the services provided during the course of the Emergency, and when Medically Necessary for stabilization and initiation of treatment. The Emergency Services must be provided by or under the direction of a Physician, and are subject to the exclusions and other provisions set out in this Policy.

"Experimental or Investigational"

A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the Federal Food and Drug Administration ("FDA"); any drug that is classified as an Investigational New Drug ("IND") by the FDA; or any drug that is proposed for off-label prescribing. As used herein, off-label prescribing

means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.

- Off-label prescribing for the treatment of cancer is not considered Experimental or Investigational.
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval.
  - Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered.
- Any health product or service whose effectiveness is unproven or is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts.

"FDA"

Federal Food and Drug Administration.

"Home Health Agency"

An organization that meets all of these tests: (a) its main function is to provide home health care services and supplies; (b) it is federally certified as a home health care agency; and (c) it is licensed by the state in which it is located, if licensing is required.

"Home Health Care Services"

Skilled nursing care and intermittent home health aide services provided in your home through a home health care agency, including physical therapy, speech therapy, occupational therapy, and medical supplies for the treatment of an illness or injury.

"Hospice"

An organization or entity whose primary purpose is to furnish medical services and supplies only to patients who are considered to be terminally ill. The Plan has the right to determine whether a facility is a Hospice facility.

"Hospital"

An institution, operated pursuant to law, which: (a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; and (b) has twenty-four (24) hour nursing services on duty or on call. For the purpose of this definition, a facility that is primarily a place for rest, Custodial Care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

"Illness"

Physical ailment, or disease. For the purpose of this definition, the term Illness does not apply to Mental Illness or Substance Abuse.

"IND"

Investigational New Drug.

"Individual Contract"

A contract for health care services issued to and covering an individual Insured.

"Infertility"

Any medical condition causing the inability or diminished ability to reproduce.

"Infertility Services"

Those services including confinement, treatment or services related to the restoration of fertility or the promotion of conception.

"Injury"

Bodily damage, other than Illness, including all related conditions and recurrent symptoms.

"Inquiry"

Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.

"Insured"

Any Policy Holder or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for Coverage under this Agreement in accordance with its terms and conditions and for whom, or on whose behalf, Premiums have been received and accepted by the Plan.

"Institutional Review Board ("IRB")"

A university or Participating Hospital panel composed of faculty and researchers that evaluates experimental and investigational procedures.

"Maintenance Therapy"

A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition.

"Material Misrepresentation"

Medical or other information not disclosed on the application, or as it relates to Covered Services, which, if it had been disclosed, would have affected the acceptance of coverage, benefits offered or provided and/or Premium charged.

"Maternity Services"

Includes prenatal and postnatal care, childbirth, and any complications associated with pregnancy.

"Medical Director"

The Physician specified by the Plan, or his or her designee, and appropriately licensed in the practice of medicine in accordance with state law, who is responsible for medical oversight programs, including but not limited to Pre-Certification programs.

"Medically Necessary/Medical Necessity"

Medically Necessary means those services, supplies, equipment and facility charges that are not expressly excluded under this Policy and are:

- Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- Necessary to meet Your health needs, improve physiological function and required for a reason other than improving appearance;
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the service;
- Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental

agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;

- Consistent with the diagnosis of the condition at issue;
- Required for reasons other than Your comfort or the comfort and convenience of Your Physician; and
- Not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

"Medical Necessity Appeal"

An Appeal of a determination by the Plan or its designated utilization review organization that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and payment for the service is denied, reduced or terminated.

"Medicare"

Part A and Part B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

"Mental Health and Substance Abuse Designee"

The organization, entity or individual that provides or arranges Covered Mental Health and Substance Abuse services under contract to the Plan.

"Mental Illness" or "Mental Health"

Those conditions classified as "mental disorders" in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders but not including mental retardation.

"NIH"

National Institutes of Health.

"Non-Participating Provider"

A Provider who has no direct or indirect written agreement with the Plan to provide Covered Services to Insureds.

"Officer"

The person holding the office of President and/or CEO or his or her designee.

"Orthotic Appliances"

Orthotic Appliances correct or support a defect of a body form or function.

"Out-of-Pocket Maximum"

The annual limit of an Insured's payments for Covered Services, as specified in the Schedule of Benefits.

"Participating Provider"

A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to the Insured.

"Peer-Reviewed Medical Literature"

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications

that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

"Physician/Practitioner"

Means anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the Degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Physician also means Doctors of Dentistry, Chiropractic and Podiatry when they are acting within the scope of their license.

By use of this term, the Plan recognizes and accepts, to the extent of the Plan's obligation under the Policy, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.

"Plan"

Coventry Health & Life Insurance Company.

"Policy"

This document and Amendments, applicable Riders, Provider Directory, and the Schedule of Benefits together form the Policy.

"Policy Holder"

An applicant, who has elected the Plan's Coverage for himself and eligible Dependents through submission of an application form and in who's name the Policy is issued.

"Post-Service Appeal"

An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

"Pre-Certification"

The Plan has given approval on a Pre-Service request for payment for Covered Services to be rendered by a Participating or Non-Participating Provider. Pre-Certification does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

"Preventive Services"

Shall mean the services set forth in Section 2713(a)(1) of the federal Public Health Service Act. A list of the preventive services covered available on our website at [www.chckansas.com] or will be mailed to you upon request.

"Pre-Existing Condition"

Any condition for which You received medical advice, diagnosis, care, treatment or recommended treatment from an individual licensed or similarly authorized to provide such services under applicable state law within the twelve (12) month period prior to the effective date of your Coverage. A condition may be defined as Pre-Existing whether physical or mental, and regardless of the cause of the condition. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition relating to such information.

"Pre-Existing Condition Exclusion Period"

The period of time for which Covered Services are excluded for a Pre-Existing Condition. The Pre-Existing Condition Exclusion Period begins on Your Effective Date of Coverage.

"Pre-Service Appeal"

An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Pre-Certification.

"Premium"

The monthly fee required from Insured in accordance with the terms of the Policy.

"Prosthetic Devices"

Prosthetic Devices aid body functioning or replace a limb or body part. Prosthetic Devices can be either internally or externally placed.

"Provider"

A Physician, Hospital, or Ancillary Provider or other duly licensed health care facility or practitioner, certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received.

"Provider Directory"

A listing of Participating Providers. Please be aware that the information in the directory is subject to change and will be updated at least annually.

"Reconstructive Surgery"

Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) The definition of Reconstructive Surgery includes the following: reconstructive surgery following a mastectomy, including on the opposite breast to restore symmetry and Prosthetic Devices/implants or reduction mammoplasty; and reconstructive surgery for a Covered newborn.

"Reformation"

Amendment of benefits, Coverage or Premium charged to a level or form different than originally issued to an Insured. The Plan may initiate adjustments to Premium in the event of a Material Misrepresentation that led the Plan to provide Coverage at the original rates quoted.

"Reinstatement"

Means restoring a Policy that has been terminated for example, because of nonpayment of Premiums.

"Rescission or Rescind"

Termination of Your Coverage, retroactive to the effective date of Coverage under this Policy. When Coverage is rescinded, the Plan refunds all Premiums paid, and recovers all payments made on behalf of the applicant. Therefore, the Plan and You are returned to a financial position as if no Coverage had ever been in force. The Plan may initiate this action in the event of a Material Misrepresentation that led to the issuance of Coverage under the Policy.

"Rider"

An Amendment that modifies Covered services and is attached to the Policy. Services provided by a Rider may be subject to payment of additional Premiums.

"Self-Injectables"

Injectable Prescription Drugs as specified in the Plan's formulary list, that are commonly and customarily administered by the Insured according to clinical guidelines used by the Plan.

"Semi-private Accommodations"

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations

are Medically Necessary.

"Service Area"

The geographic area served by the Plan. The Plan's Service Area is subject to change from time to time.

"Skilled Nursing Facility ("SNF")"

A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related services. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily Custodial Care, including training in Activities of Daily Living.

"Substance Abuse"

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

"Therapeutic Injections and IV Infusions"

Prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the Insured.

"Total Disability"

Complete inability of the Insured to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Insured to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. The disability of the Insured must require regular care and attendance by a Physician who is someone other than an immediate family member.

"Urgent Care"

A condition that requires prompt medical attention due to an unexpected Illness or Injury. These conditions may also constitute Emergencies in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

"Urgent Care Appeal"

An Appeal for which a requested service requires Pre-Certification, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of the Insured or the Insured's unborn child; or (b) the Insured's ability to regain maximum function. In determining whether an Appeal involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

"Utilization Review"

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, Pre-Certification, concurrent review, case management, and discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of Coverage.

"We, Us or Our"

Coventry Health & Life Insurance Company.

"You or Your"

The Insured Covered under this Policy.

Acceptance Of This Policy

By selecting Coverage pursuant to this Policy, and by seeking or accepting care or Covered Services, You agree to all of the terms, conditions, and provisions of this Policy, including any Riders and Amendments hereto.

Identification ("ID") Card

Every Insured will receive an ID card. Carry Your ID card with You at all times, and present it every time You request or receive services. The ID card is needed for Providers to bill the Plan for charges other than Copayments, Coinsurance, and non-Covered Services. If You do not show Your ID card, the Providers cannot identify You as an Insured of the Plan, and You may receive a bill for services. If Your ID card is missing, lost, or stolen, contact the Plan's Customer Service Department at [800-969-3343] or through the website at [www.chckansas.com] to obtain a replacement. This information is also listed on the ID card and in the Schedule of Important Numbers. Possession and use of an ID card is not an entitlement to Coverage. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in this Policy.

Health Services Rendered By Participating Providers

An Insured has access to the services of a Participating Provider of their choice within the Provider network when receiving In-Network Covered Services, subject to the terms, conditions, exclusions and limitations of the Policy. Coverage for services described in this Policy and the Schedule of Benefits include services that (a) are Medically Necessary and (b) are provided by or under the direction of a Participating Provider and (c) are Pre-Certified, if required, in advance. The telephone number for Pre-Certification is listed on Your ID card and in The Schedule Of Important Telephone Numbers And Addresses of this Policy. Participating Providers are contractually obligated to file all claims for You.

It is the Insured's responsibility to verify the participation status of Providers. You should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Insured is responsible for verifying the status of the Provider by contacting the Customer Service Department or by checking the Plan's website at [www.chckansas.com].

Coverage for services is subject to timely payment of the Premium required for Coverage under the Plan and payment of the Copayment, Coinsurance and/or Deductible specified for any service. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not the Provider. To verify Coverage of services or Provider participation status, please contact the Customer Service Department.

Notice of Claim

The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits. A Non-Participating Provider may or may not complete and file the claim form for You. Written notice of claim must be submitted to the Plan within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonable.

Claim Forms

You may obtain a Non-Participating claim form from the Plan's Customer Service Department

within fifteen (15) days from the date the Plan receives notice of a claim from You. If a Non-Participating claim form is not provided to You within fifteen (15) days after the Plan receives notice of a claim, You shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting written proof covering the occurrence, character, and extent of loss, within the time fixed for filing a claim.

Proofs of Loss

It is your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of your claim. The Plan requests that You file the Non-Participating Provider claim within ninety (90) days from date of service. However, failure to file the claim within the ninety (90) day period shall not invalidate or reduce the claim, if it was not reasonably possible to provide notice or proof within the ninety (90) days. A claim will not be denied based upon the Insured's failure to submit a claim within the ninety (90) day period. However, claims may not be accepted, except in the absence of legal capacity of the claimant, when You submit proof of loss to the Plan more than twelve (12) months from the date services were provided by the Non-Participating Provider.

Processing of the Filed Claim

We make claim payment decisions based on the information provided on the submitted claim form. We make every effort to process claims upon receipt of the Proof of Loss. All Covered Services payable under the Policy shall be paid not more than thirty (30) days after receipt of the completed claim form, and subject to the Proof of Loss provision of this Policy. If We deny all or part of Your claim, We will send You an Explanation of Benefits form or a letter explaining why it was denied under the terms of the Policy. We will also notify You if additional information is necessary to process the claim.

Non-Participating Provider Fees

Payment for Covered Services provided by Non-Participating Providers is limited to the lesser of the billed charge or the Out-of-Network rates listed below less applicable Copayments, Coinsurance and/or Deductibles. These rates are calculated as a multiple of the Medicare fee schedule for Physicians, Hospitals, outpatient facilities, ancillary providers and other providers. These rates may be adjusted from time to time.

If the amount You are charged for a Covered Service is equal to or less than the Out-of-Network rate, the charge should be completely covered by Your Out of Network benefit, except for any Copayment, Coinsurance, and/or Deductible payments You must make. However, if the amount You are charged is in excess of the Out-of-Network rate for a particular Covered Service, you will be responsible for paying any amounts in excess of the rates listed below, in addition to any applicable Copayment, Coinsurance, and/or Deductible payments.

- **Non-Participating Physician and Other Health Care Professional Fees**
  The Out-of-Network rate is equivalent to 100% of the national average Medicare rate, based on the prior year Resource Based Relative Value Scale ("RBRVS") fee schedule for Physician and other health care profession services, as such services are defined in the American Medical Association's Current Procedural Terminology ("CPT") manual. For Physician and other health care profession services not valued in RBRVS, other Medicare or nationally recognized schedules will be used. For CPT codes developed after the prior year, the rate will be calculated using the assigned Relative Value Units ("RVU") and the prior year Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the First Data Bank Average wholesale Price ("AWP"). Payment for

anesthesia services will be 200% of the prior year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment ("DME"), prosthetics, orthotics and supplies ("DME POS") will be at the prior year DME POS ceiling limit. Payment for Laboratory services will be at the prior year Medicare Clinical Laboratory Fee Schedule. If there is no corresponding rate, as described above, for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.

- **Non Participating Facility Fees**
  The Out-of-Network rate is equivalent to 100% of the Medicare base rate for facility charges. Payment for inpatient services will be based on Diagnosis Related Group ("DRG") rates. Payment for outpatient services will be based on Ambulatory Payment Classification ("APC") rates. Payment for services provided within an ambulatory surgical center will be based on Ambulatory Surgical Center ("ASC") group rates. If there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.

Please note that Physician and Hospital charges typically are not regulated. Billed charges can vary tremendously from one provider to the next, so please make sure you are aware of the billed charge for services you want to receive from Non-Participating Providers.

Pre-Certification

Pre-Certification is required for certain Covered Services as determined by the Plan, such services include Hospital Admissions and related services, selected outpatient procedures, and all transplants. It is the Insured's responsibility to verify that Pre-Certification has been obtained from the Plan prior to receiving Covered Services. A list of current Pre-Certification procedures is provided to You. To request a copy contact the Plan's Customer Service Department's telephone number listed on Your ID card or by visiting the Plan's website at [www.chckansas.com].

Any new, additional or extended services not Covered under the original Pre-Certification will be Covered only if a new Pre-Certification is obtained. All services identified in this Policy are subject to all of the terms, conditions, exclusions and limitations of the Plan, even if the Participating Provider requests the Pre-Certification on behalf of the Insured.

Failure to obtain Pre-Certification will result in a reduction of benefits. To find out the amount of the penalty, please see the Schedule of Benefits. Any penalty applied does not apply to the Out-of-Pocket Maximum, the Deductible or Coinsurance amount. It is the Insured's responsibility to verify that Pre-Certification has been obtained before receiving services.

It is important to note that under the terms of the Plan, Pre-Certification only determines medical necessity and appropriateness, all other terms of the Plan are then applied. If the Plan Pre-Certifies Covered Services, the Plan shall not subsequently retract the Pre-Certification after the Covered Services have been received, or reduce payment unless: (1) Such Pre-Certification is based on a Material Misrepresentation or omission about the Insured's health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) the Insured's Coverage under the Plan terminates before the health care services are provided.

Second Opinion Policy

An Insured may seek a second medical opinion or consultation from any Provider. An Insured

should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits and subject to the terms, conditions, exclusions and limitations of the Policy.

Copayments, Coinsurance and Deductibles

You are responsible for paying Copayments to Providers at the time of service. The Provider may bill You at a later time for the Coinsurance amounts that are Your responsibility under the terms of the Plan as determined by the contracted rates that have been established between the Plan and the Participating Providers or as determined by the Plan's Non-Participating Provider fee schedule when services are rendered by a Non-Participating Provider. You must meet the applicable Deductible, as described in your Schedule of Benefits, before benefits will be payable to Providers on Your behalf. Specific Copayments, Coinsurance amounts and Deductibles are listed in the Schedule of Benefits. A Copayment is defined as a dollar amount, while Coinsurance is typically defined as a percentage of Eligible Expenses.

How to Contact The Plan

Throughout this Policy, You will find that the Plan encourages You to contact the Plan for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact the Plan at the telephone number or website on the back of Your ID card.

Telephone numbers and addresses to request review of denied claims, register Complaints, place requests for Pre-Certification, and submit claims are listed in the Schedule of Important Telephone Numbers And Addresses included in this Policy.

Participating Provider Hold Harmless

Participating Providers agree that in no event, including but not limited to nonpayment by the Plan or intermediary, insolvency of the Plan or intermediary, or breach of this Policy, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against the Insured or a person, other than the Plan or intermediary, acting on behalf of the Insured for services provided pursuant to this Policy. This Policy shall not prohibit the Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the EOC, or fees for non-Covered Services delivered on a fee-for-service basis to You. The provider hold harmless provision shall not prohibit a Provider and You from agreeing to continue services solely at Your expense, as long as the Provider has clearly informed You that the Plan may not cover or continue to cover a specific service or services. Except as provided herein, this provision does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing Coverage to You.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Policy. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Illness or Substance Abuse, or Mental Illness does not mean that the procedure or treatment is Covered under the Policy. The Plan shall have the right, subject to Your rights under this Policy, to interpret the benefits of this Policy and attached Riders, and other terms, conditions, limitations and exclusions set out in the Policy in making factual

determinations related to the Policy, its benefits, and the Insured; and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw or add benefits to, or terminate this Plan. Any termination of the Policy must be in accordance with Eligibility & Termination of this Policy. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

Policy Holder Eligibility - To be eligible to be enrolled You must:

- Meet any eligibility criteria specified by the Plan;
- Be under the age of 65 and not eligible for Medicare;
- Pay required premiums when due; and
- Complete and submit to the Plan such application or forms that the Plan may reasonably request.

Dependent Eligibility - To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

Be the lawful Spouse of the Policy Holder or be a child of the Policy Holder or the Policy Holder's Spouse including:

- Children up to age twenty-six (26) who are either the birth children of the Policy Holder or the Policy Holder's Spouse or legally adopted by or placed for adoption with the Policy Holder or Policy Holder's Spouse;
- Children up to age twenty-six (26) for whom the Policy Holder or the Policy Holder's Spouse is required to provide health care Coverage pursuant to a Qualified Medical Child Support Order;
- Children up to age twenty-six (26) for whom the Policy Holder or the Policy Holder's Spouse is the court-appointed legal guardian;
- Coverage will be extended for children age twenty-six (26) who meet the Eligibility requirements, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Policy Holder or the Policy Holder's Spouse for support and maintenance, provided that: the onset of such incapacity occurred before age twenty-six (26), proof of such incapacity is furnished to the Plan by the Insured upon enrollment of the Dependent child or at the onset of the Dependent child's incapacity prior to reaching the limiting age and annually thereafter;

Service Area – The Service Area includes all counties within the State of Arkansas.

Medical Underwriting - Eligibility for Coverage under this Policy is based on health-related factors, excluding genetic testing. An evaluation of the applicant's medical history will determine acceptance and final Premium for this Coverage.

- In order to determine acceptance the Plan will review the Medical Questionnaire information from the Application agreement.
- If minor clarification is needed the Plan will send an additional questionnaire and ask You to complete the form.
- If more detailed information is needed additional medical information may be requested from the Provider listed on the Application agreement Medical Questionnaire or additional information provided by You.
- If we have not received the information requested within thirty (30) days, the application will be deemed denied.

Persons Not Eligible to Enroll

- A person who fails to meet the eligibility requirements specified in this Policy shall not be eligible to enroll or continue enrollment with the Plan for Coverage under this Policy.

- A person whose Coverage was terminated due to a violation of a material provision of this Policy shall not be eligible to enroll with the Plan for Coverage under this Policy.

- A person who is on active duty in the armed forces of any country shall not be eligible to enroll.

- Except as otherwise specifically stated in the Policy or as required by law, initial enrollment is limited to individuals who are not eligible for Title XVIII of the Social Security Act 49 Stat. 620 (1935), 42 USCA 301 as amended (Medicare) or any similar program sponsored by the federal government or a state government.

  If you become eligible for Medicare while you are covered under this Policy, you should enroll for and maintain coverage under both Medicare Part A and Part B.

  When you reach age 65, we will assume that you have enrolled in Medicare Part A and Part B.

Special Enrollment Due to New Dependent Eligibility - Subject to the conditions set forth below, a new Dependent of the Policy Holder or the Policy Holder's Covered Spouse may enroll in the Plan if the Policy Holder or the Policy Holder's Covered Spouse has acquired a Dependent through marriage, birth, adoption or placement for adoption.

- New Spouse Due to Marriage. Subject to the Medical Underwriting provisions noted above, the Policy Holder's new Spouse may enroll at any time after marriage.

- New Dependents Due to Birth. A newborn child born to the Policy Holder or the Policy Holder's Covered Spouse may be Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first five (5) days from the date of birth or until the mother is discharged, whichever is earlier. For Coverage to continue beyond the first five (5) days, an Application agreement to enroll the newborn must be received within ninety (90) days from the date of birth, and subject to all eligibility requirements.

- New Dependents Due to Adoption. A child who becomes a Dependent as a result of adoption or placement for adoption, may enroll within sixty (60) days from the date of adoption or placement for adoption.

- If application to enroll the new Dependent is submitted beyond the time limits noted above, the application will be subject to the medical underwriting provisions.

Notwithstanding the above, a common law Spouse qualifies as a Spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.

Effective Date. Coverage shall become effective on the Effective Date indicated in the notification of acceptance the Plan sends You. You will receive such notification when the Plan receives a completed Application Form and approves the enrollment. You will not be enrolled until You receive such notice. Your payment of the applicable premium is considered to be your acceptance of Coverage.

Notification of Change in Status. You must notify the Plan of any changes in Your status within thirty (30) days of the event. Submit this notice to the Plan's Customer Service Department at [(800) 969-3343] or through the website at [www.chckansas.com]. Events qualifying as a change in status and requiring notice include, but are not limited to, change in name or address, and Medicare eligibility. We should be notified within a reasonable time of the death of the Insured.

Termination of Policy and Renewal This Policy shall be renewable at the option of the Insured, except as described immediately below. Non-renewal shall not be based upon the deterioration of mental or physical health of the Insured under this Policy.

Your Coverage shall terminate if any one of the following events occurs:

- **Loss of Eligibility.** If You no longer meet the eligibility requirements set forth in this Policy, Your coverage shall end at 11:59 p.m. on the date You no longer meet the eligibility requirements.

- **Rescission of Coverage.** Coverage for an Insured under this Policy may be canceled, Reformed or Rescinded based on medical or other enrollment or eligibility information received which was not properly or completely disclosed, or was falsely disclosed in Your Application agreement, prior to contracting or enrollment. NOTE: If an Insured's coverage is Rescinded, as described in this section, coverage will be termed back to the effective date and the Plan will seek recovery of all payments made on the Your behalf. Therefore, both the Plan and the Insured will be returned to a financial position as if no coverage had ever been in force. The Plan may initiate this action in the event that, among other possible reasons, there is a Material Misrepresentation that led the Plan to provide coverage. However, an Insured's coverage will not be Rescinded due to improper disclosure on the Application agreement after coverage has been in effect for two years. This exception does not apply in the case of fraudulent misrepresentation.

- **Non-payment of Premiums.** You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the ten (10) day grace period, you will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the ten (10) day grace period.

- **Change in Status.** In the event You change Your place of residence within Our Service Area, You will be offered an opportunity to enroll in a new Policy. [If you move outside Our Service Area you will be notified within thirty (30) days, of your Policy termination.]

- **Fraud.** You participate in fraudulent or criminal behavior, including but not limited to:

  - √ Performing an act or practice that constitutes fraud or Material Misrepresentation of facts including, but not limited to using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled.

  - √ Allowing any other person to use Your identification card to obtain services. If the Insured allows any other person to use his/her identification card to obtain services, the Coverage of the Insured will be terminated.

  - √ Knowingly misrepresenting, omitting or giving false information on any Policy forms and medical questionnaire.

Premium Payment

Amount of Premium. The monthly premium due for Your coverage under this Policy is stated in the proposal page and may be updated as explained below.

Payment of Premium. The first premium payment(s) is due no later than ten (10) days after the effective date of Your Policy. (For example, Your policy begins July 1, Your premium is due by the 10th of July and must be paid by the 10th of each month.) Premium payments for subsequent months shall be due on the 10th day of each month.

All premium payments must be automatically deducted from either a checking or savings account of a banking institution. If funds are not available at the time of the automatic deduction, You will receive a notice that payment is due directly to Coventry Health & Life Insurance Company. The Plan may impose a service charge when payments are refused and/or returned by the Your financial institution, such as, but not limited to, an account with non-sufficient funds available. Payments should be sent to:

Coventry Health & Life Insurance Company

[P.O. Box 6512
Carol Stream, IL 60197-6512]

Grace Period. You are granted a Grace Period of ten (10) days to make payment of every premium due. This means that if Your premium is not paid on the date that it is due, You must pay it within the following ten (10) days. This Policy will remain in force during this Grace Period. If You do not pay Your total premium by the end of the Grace Period, Your coverage will be retroactively terminated to the date covered by Your last paid premium.

Changes in Premiums. The Plan reserves the right to change Premiums upon ten (10) days written notice to the Policyholder.

- We will automatically change the amount of Your Premium should a birthday place You into the next age classification upon which Premiums are based.

- We may also change the amount of Your Premiums, upon ten (10) days written notice if the Premiums of Your entire age classification are changed.

Effect of Termination.

If Your Coverage under this Policy is terminated, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination.

- Identification cards are the property of the Plan and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.
- Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Grievance and Complaint procedures. The Plan may not terminate the Policy solely for the purpose of effecting the disenrollment of the Insured for either of these reasons.
- If the Insured receives Covered Services after the termination of Coverage, the

Plan may recover the contracted charges for such Covered Services from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

§ Upon the death of an insured, premiums paid for Coverage for the insured for any period beyond the end of the policy month in which the death occurred shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the insurer.

Reinstatement of Coverage

If any renewal Premium is not paid within the time granted the Insured for payment, a subsequent acceptance of Premium by the Plan or by any agent duly authorized by the Plan to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Plan or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Policy will be reinstated upon approval of such application, by the Plan, or lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the Plan has previously notified the Insured in writing of its disapproval of such application.

The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the Insured and the Plan shall have the same rights there under as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date or reinstatement.

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the Policy, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued. If the Plan elects to discontinue offering all health insurance Coverage in the individual market, You will receive a written notice of discontinuation at least one hundred and eighty (180) days before the date the Coverage will be discontinued. Termination of the Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period the Policy was in force may be predicated upon the continuous injury or illness of the insured, limited to discharge or replacement of the Policy.

Certificates of Creditable Coverage.

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

Covered Services

The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Pre-Certified, if Pre-Certification is required, (3) not expressly excluded in the list of Exclusions and Limitations section as set forth in this Policy, and (4) incurred while the Insured is eligible for Coverage under the Plan. It is the Insured's responsibility to verify whether a Covered Service requires Pre-Certification and should always reference the Schedule of Pre-Certification Requirements prior to receiving Covered Services. You should not assume that a Participating Provider has already accomplished the Pre-Certification.

The following section, **Schedule of Covered Services**, provides the services and supplies Covered under this Policy. The schedule is provided to assist You with determining the level of Coverage, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in this Policy. If a service is not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service.

Please note that the Covered Services in the schedule below are subject to all applicable Exclusions and Limitations of this Policy.

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Allergy	Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	**Exclusions:** See Exclusion Section relating to allergy services.
Ambulance (air and ground)	Coverage is provided for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency services can be rendered.	**Exclusions:** See Exclusion Section regarding ambulance services.
Blood and Blood Products Processing	Coverage is provided for administration, storage, and processing of blood and blood products in connection with services Covered under this Policy.	**Exclusions:** See Exclusion Section regarding blood and blood products.
Breast Reconstruction	Coverage is provided for breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy resulting from diagnosed cancer. As required by the Women's Health and Cancer Rights Act ("WHCRA"), if You elect breast reconstruction after a Covered mastectomy, benefits will be provided for (1) augmentation and reduction of the affected breast, (2) augmentation or reduction on the opposite breast to restore symmetry, (3) prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction.	**Exclusions:** See Exclusion Section regarding Reduction or Augmentation Mammoplasty.
Cardiac Rehabilitation Services	Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Chemotherapy	Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer.	**Limitations:** Chemotherapy benefit is subject to the Plan's Experimental and Investigational exclusion.
Colorectal Cancer Screening	Coverage is provided for a colorectal cancer exam and related laboratory testing for any asymptomatic Insured pursuant to the Plan's criteria, which are in accordance with the current American Cancer Society and U.S. Preventive Services Taskforce guidelines.	
Contraceptive Devices	Coverage is provided for contraceptive implants, diaphragms, and IUDs (including their insertion and removal), as specifically provided in the Schedule of Benefits. Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider.	
Dental Services	Coverage is provided for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if: (1) The provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and (2) The patient is: (A) A child under seven (7) years of age who is determined by two (2) dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; (B) A person with a diagnosed serious mental or physical condition; or (C) A person with a significant behavioral problem as determined by the Insured's physician. If a person is covered under both this Plan and a benefit plan that provides dental benefits, the health benefit plan that includes dental benefits is the primary payer.	Limited benefit. **Exclusions:** See Exclusions Section regarding dental services.
Dermatological Services	Coverage is provided for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Dialysis	Coverage is provided for hemodialysis and peritoneal services provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.	
Diabetic Supplies	Coverage includes Plan approved glucose meters and self-management training used in connection with the treatment of diabetes.	**Limitations:** Disposable insulin syringes, glucose strips, and lancets are Covered under the pharmacy Rider. If a pharmacy Rider is not purchased, Coverage for this benefit will be provided under this Policy.
Durable Medical Equipment ("DME")	Coverage is provided when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member. The wide variety of DME and continuing development of patient care equipment makes it impractical to provide a complete listing of Covered or non-Covered equipment here. Therefore, the Plan may approve requests on a case by case basis. The Plan may rent or purchase DME.	Upgrades to equipment are the responsibility of the Insured. **Exclusions:** See Exclusions Section regarding DME Coverage.
Emergency Services	Coverage is provided for health services and supplies furnished or required to screen and stabilize an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. The determination of Covered Services for services rendered in an emergency facility is based on the prudent layperson standard, along with those relevant symptoms and circumstances that preceded the provision of care. Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and Pre-Certification is not required.	You should notify Your Physician and the Plan within 48 hours of admission or the next business day or as soon as physically able.
Eye Glasses and Corrective Lenses	Not a Covered Service, except for the first pair of eyeglasses or corrective lenses following cataract surgery	**Exclusions:** See Exclusions Section regarding eyeglasses and contact lenses.
Genetic Counseling and Studies	Coverage is provided for genetic counseling and genetic studies only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities and the testing will alter the	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	outcome of treatment.	
Gynecological Examinations	Coverage is provided for routine well-woman examinations, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society and the U.S. Preventive Services Taskforce Guidelines.	
Hearing Screenings	Coverage is provided for a hearing screening to determine hearing loss.	
Home Health Care Services	Coverage is provided when all of the following requirements are met: (1) the service is ordered by a Physician; (2) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, respiratory therapist, or occupational therapist; (3) part-time intermittent services are required; (4) a treatment plan has been established and periodically reviewed by the ordering Physician; and (5) the agency rendering services is licensed by the State of location.	**Exclusions:** See Exclusions Section regarding Home Services.
Hospice	Coverage is provided for hospice care rendered by a Provider for treatment of a terminally ill Insured when ordered by a Physician. Care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the Illness, and guidance and assistance during the Illness for the purpose of preparing the Insured and the Insured's family for a terminal Illness.	
Inpatient Hospital Care	Coverage includes semi-private accommodations and associated professional and ancillary services. Certain services rendered during the Insured's Confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits and Schedule of Exclusions.	**Exclusions:** See Exclusions Section regarding Private inpatient room.
Laboratory and Pathology Services	Coverage is provided as listed in the Schedule of Benefits.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Newborn Care	The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, Reconstructive Surgery for the treatment of medically diagnosed congenital defects or birth abnormalities. Coverage is provided for all eligible newborns to be tested or screened for phenylketonuria ("PKU") and such other common metabolic or genetic diseases. Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.	.
Nutritional Counseling	Coverage is provided when provided by a registered dietician and when the Insured is diagnosed with diabetes.	
Oral Surgery and Diseases of the Mouth	Coverage includes only oral surgical services limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect. Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin.	**Exclusions:** See Exclusions Section regarding oral surgery and dental services.
Orthotic Devices	Coverage is provided for the initial purchase of Orthotic Appliances following the onset or initial diagnosis of the condition for which the device is required. Coverage is provided for Orthotic Appliances, splints and braces, including necessary adjustments to shoes to accommodate braces. Shoe inserts will be Covered only if the Insured has diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace.	**Exclusions:** See the Exclusions Section regarding Orthotic Appliances.
Osteoporosis	Coverage is provided for services related to diagnosis, including central bone density tests; medically necessary treatment and appropriate management of osteoporosis. In determining medical appropriateness, due consideration shall be given to peer-reviewed medical literature.	
Outpatient Diagnostic Services	Coverage is provided for services and supplies for outpatient diagnostic services provided under the direction of a Provider at a Hospital or Alternate Facility. Coverage for testing pregnant women and children for lead poisoning shall be covered as any	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	other outpatient diagnostic service. Also covered is human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing for A, B, and DR antigens.	
Outpatient Surgery	Coverage is provided for services and supplies for outpatient surgery provided under the direction of a Provider at a Hospital or Alternate Facility.	
Outpatient Therapy Services	Coverage is provided for short-term outpatient therapy services that are expected to result in significant functional improvement of the Insured's condition, limited to physical therapy, occupational therapy, and speech therapy. Speech therapy is covered for loss or impairment of speech or hearing. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and which fall within the scope of his/her license or certification.	**Exclusions:** See Exclusions Section.
PKU or any other Amino and Organic Acid Inherited Disease Formula/Food	Coverage is provided for formula and/or food used for PKU or any other amino and organic acid inherited disease that is recommended by a Provider as determined by the Plan to be Medically Necessary.	
Physician Services	Coverage is provided for Physician Services, including but not limited to, office visits, Hospital visits, consultations, and interpretation of tests.	
Preventive Services	The preventive health services referenced below shall be covered in full and are not subject to cost-sharing requirements (including co-payments, co-insurance and deductible), in a manner consistent with Section 2713 of Federal H.R. 3590. A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force; B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention ("ACIP - CDC"); C. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	D. Additional preventive care and screenings for women (including breast cancer screening and mammography screenings) not described in paragraph (A). A list of the preventive services covered under this paragraph is available on our website at [www.chckansas.com] or will be mailed to You upon request. You may request the list by calling the Customer Service number on Your identification card.	
Prosthetic Devices	Coverage is provided for the initial purchase of Prosthetic Devices following the onset or initial diagnosis of the condition for which the device is required. For Prosthetic Device placements requiring a temporary and then a permanent placement only one (1) temporary device will be Covered. Coverage is provided for Prosthetic Devices, including but not limited to, purchase of artificial limbs, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. Coverage is provided for external Prosthetic Devices that are used in lieu of surgery for breast reconstruction due to a mastectomy. Coverage will be provided for replacement of Prosthetic Devices, which become non-functional and non-repairable due to: (1) A change in the physiological condition of the Insured; (2) Irreparable wear or deterioration from day-to-day usage over time of the device; or (3) The condition of the device requires repairs and the cost of such repairs would be greater than the cost of a replacement device. Prosthetics will be replaced for documented growth in a child requiring replacement. Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.	Coverage for Prosthetic devices will be subject to the benefit limit as expressed in the Schedule of Benefits. Coverage for internal prosthetic devices, including but not limited to, artificial heart valves, artificial joint appliances, orthopedic implants, will not be subject to the benefit limit. **Exclusions:** See Exclusions Section regarding Prosthetic Devices.
Pulmonary Rehabilitation Services	Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.	
Radiation Therapy	Coverage is provided for standard radiation therapy.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Radiology	Coverage is provided as determined by the Plan.	
Reconstructive Surgery	Services are limited to the surgical correction of congenital birth defects or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment.	**Limitations:** Coverage for reconstructive surgery for a congenital birth defect shall be Covered only for dependent children [through age eighteen (18)]. **Exclusions:** See Exclusions Section regarding Cosmetic Services and Surgery.
Rehabilitation Services and Supplies	Coverage is provided for short-term inpatient or outpatient rehabilitation services which are expected to result in significant functional improvement of the Insured's condition. Rehabilitation services must be performed by a Provider, including a free standing rehabilitation facility.	**Exclusions:** See Exclusions Section regarding rehabilitation services and supplies.
Sleep Studies	Covered Services.	**Exclusions:** See Exclusion Section regarding sleep studies.
Skilled Nursing Facility Services	Coverage is provided for Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of a Provider in a Skilled Nursing Facility. Services rendered in a Skilled Nursing Facility are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan.	**Limitations:** Coverage in a Skilled Nursing Facility may be subject to a Benefit Year limitation as specified in the Schedule of Benefits. Certain ancillary services rendered during the Insured's Confinement are subject to separate benefit restrictions and/or Insured responsibilities as described elsewhere in this Policy or in the Schedule of Benefits.
Spinal Manipulation Services	The following services are Covered when they are delivered by a duly licensed Provider acting within the scope of his or her license: • Initial Examinations Coverage includes the initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder. This examination is performed to determine the nature of the Insured's problem. Examinations should be limited to the portion of the body in which the symptoms are being experienced. A more thorough examination of the bodily systems	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	may be done if appropriate clinical indications are present and documented. Vital signs should be included in examinations when appropriate. • Subsequent Office Visits This may include an adjustment, a brief examination and other Medically Necessary services. • Re-examination This is performed to assess the need to continue, extend, or change the course of treatment. A re-evaluation may be performed during a subsequent office visit.	
Sterilization (voluntary)	Covered Service.	**Exclusions:** See Exclusions Section regarding reversal of sterilization.
Therapeutic Injections and IV Infusions.	Coverage is provided for Injectable and Self-Injectable medications when FDA-approved, medically appropriate subject to the Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan.	**Limitations:** Certain Self-Injectable medications may be Covered by a pharmacy Rider and therefore excluded from the medical benefit. **Exclusions:** See Exclusions Section regarding Prescription medications.
Transplants	Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Coventry Transplant Network participating facility and the recipient is an Insured. Donor screening tests are Covered and when performed at a Coventry Transplant Network participating facility. If not Covered by any other source, the cost of any care, including complications up to 90-days, arising from an organ donation by a non-Insured when the recipient is an Insured will be Covered for the duration of the Policy. Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants.	**Exclusions:** See Exclusions Section regarding transplant services.

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	The cost of any care, including complications, arising from an organ donation by the Insured when the recipient is not an Insured is excluded. If the Insured resides more than one hundred-fifty (150) miles from the transplant facility, reimbursement for travel will be Covered. Travel expenses may include the lodging for one family member or responsible adult. Lifetime limitation for travel and lodging are determined by the Plan.	
Urgent Care Services	Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention. If possible, please contact Your Physician in the event Urgent Care services are/were rendered. Your Physician is available to provide guidance and direction in situations that may require Urgent Care. However, failure to notify Your Physician will not result in denial of Coverage. If Medically Necessary follow-up care related to the initial Urgent Care service is required, you should contact and coordinate with Your Physician.	
Vision Services	Coverage is provided for eye examination to include, if Medically Necessary, medical history; evaluation of visual acuity; external examination of the eye; binocular measure; ophthalmoscopic examination; medication for dilating pupils and desensitizing the eyes for tonometry; summary and findings, a determination as to the need for correction of visual acuity, prescribing lenses, if needed.	**Exclusions:** See exclusions section regarding Vision Services.

[Pre-Existing Conditions Limitation

Pre-Existing Conditions may affect Your premium rate, may result in denial of Your application, or We may deny Coverage for them for a period of time after Your effective date. If You are accepted for Coverage, Your premium rate will be calculated to include any Pre-Existing Condition that You disclosed on Your enrollment form, and such conditions will be Covered under the terms of Your Policy beginning on Your effective date. Any Pre-Existing Condition(s) that is not disclosed on Your enrollment form will be excluded from Coverage for a period not longer than twelve (12) months after Your effective date .

Pre-Existing Condition Exclusions shall not apply to any Covered Person under the age of 19.]

Non-Duplication of Coverage Under Certain Laws

Motor Vehicle Coverage

This Policy will always be secondary to any state no-fault law that requires motor vehicle liability policies to provide person injury protection insurance for the insured and any passengers. Individual automobile "no fault" medical payment contracts that provide personal injury protection or no-fault benefits in excess of the minimum limits required by state law will remain primary to the limit or extent of the personal injury protection benefit provided in the automobile insurance policy. The plan benefits will be reduced by the amount of the personal injury protection coverage paid for by any such no-fault law or limit provided in the applicable automobile insurance policy. If a vehicle insurance policy has a provision providing personal injury protection coverage, whether required by law or not, such coverage will be primary over coverage provided by this Policy. The Insured agrees to furnish information to the Plan concerning any applicable personal injury protection insurance upon request.

Right of Recovery

The Plan has the right to correct benefit payments that are made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payments if any underpayments have been made.

General Exclusions

Unless otherwise stated in this Policy, the following items are excluded from Coverage:

1) Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Policy;

2) Any service or supply that is not Medically Necessary;

3) Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service;

4) Any service or supply for which You have no financial liability or that was provided at no charge; those services for which the Insured has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Policy;

5) Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;

6) Court-ordered services or services that are a condition of probation or parole;

7) Those services otherwise Covered under the Policy, but rendered after the date Coverage under the Policy terminates, including services for medical conditions arising prior to the date individual Coverage under the Policy terminates; and

8) Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as the Insured, or rendered by a person who is a member of the Insured's family, including Spouse, brother, sister, parent, step-parent, child or step-child.

Specifically excluded services include, but are not limited to, the following:

1) **Acupuncture -** Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not Covered;

2) **Allergy Services -** Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;

3) **Alternative Therapies** - Alternative therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;

4) **Ambulance Service -** Non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Insured;

5) **Augmentative Communication Devices –** Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Insureds;

6) **Autopsy** - Those services and associated expenses related to the performance of autopsies, and also post-mortem genetic studies;

7) **Behavior modification;**

8) **Biofeedback;**

9) **Blood and Blood Products - The cost of whole blood and blood products replacement to a blood bank;**

10) **Blood Storage** - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;

11) **Braces and supports needed for athletic participation or employment;**

12) **Charges resulting from Your failure to appropriately cancel a scheduled appointment;**

13) **Cochlear Implants** and related services;

14) **Cosmetic Services and Surgery** - Those services, associated expenses, or complications resulting from Cosmetic Surgery, which alters appearance but does not restore or improve impaired physical function. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes;

15) **Counseling Services** and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;

16) **Custodial Care**, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists the Insured in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services;

17) **Dental Services -** Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the surgical treatment of temporomandibular joint disorder ("TMJ"), whether the services are considered to be medical or dental in nature except as provided in the "Covered Services" Section of this Policy. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). The diagnosis and treatment for TMJ and craniomandibular joint disease is not Covered unless by an attached Rider. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;

    Also excluded from coverage are dental services when such services are directly related to an accidental injury. This includes but is not limited to treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an accidental injury.

    Removal of teeth, including any prophylactic extractions, as a complication of radionecrosis is not a Covered Service

18) **Dental Surgery and Implants** - Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded.;

19) Medical services and expenses incurred for learning disabilities, **developmental delays**, mental retardation, and autistic disorders.

20) **Durable Medical Equipment ("DME")** - Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home blood pressure monitoring devices; home oximetry units; home traction units; replacement for changes due to obesity; preventive or routine maintenance due to normal wear and tear or negligence of items owned by the Insured; personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services;

21) **Educational Services** Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;

22) **Equipment** or services for use in altering air quality or temperature;

23) Educational testing or psychological testing, unless part of a treatment program for Covered Services;

24) **Elective or Voluntary Enhancement -** Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition,

service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan;

25) **Eligible Expenses** - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;

26) **Enteral Feeding Food Supplement** - The cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

27) **Examinations** - Unless otherwise Covered under the Covered Services Section, those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, travel, employment, insurance, marriage or adoption. Also excluded are services relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type;

28) **Exercise equipment**, hot tubs and pools;

29) **Eye Glasses and Contact Lenses** - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;

30) **Food or food supplements ,** regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease;

31) **Foot Care** – Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Insured;

32) **Foreign Travel -** care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services;

33) **Growth Hormone –** Growth hormone therapy for any condition, except in children less than 18 years of age who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan;

34) **Hair analysis, wigs and hair transplants -** Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Provider;

35) **Home services to help meet personal, family, or domestic needs;**

36) **Health and Athletic Club Membership** - Any costs of enrollment in a health, athletic or similar club;

37) **Hearing Services and Supplies** - Those services and associated expenses for hearing aids, cochlear implants, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests, unless Covered by an attached Hearing Aid Rider;

38) **Household Equipment and Fixtures** - Purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;

39) **Hypnotherapy and Hypnosis;**

40) **Immunizations** unless specifically covered under the Policy, including but not limited to immunizations required for travel, school, work-related, Anthrax vaccine and Lyme Disease vaccine. Also excluded are examinations and testing in connection with insurance, obtaining employment, specifically for the purpose of entering school, participating in extracurricular school activities, adoption, immigration and naturalization, or examinations or treatment ordered by a court or an employer; premarital blood testing;

41) **Infertility/Reproductive Services** - All diagnostic studies, non-diagnostic services, and certain surgical procedures that are related to diagnosing and/or treating Infertility. Also excluded are expenses incurred for the promotion of conception including, but not limited to, artificial insemination, intracytoplasmic sperm injection ("ICSI"), in vitro or in vivo fertilization, gamete intrafallopian transfer ("GIFT") procedures, zygote intrafallopian transfer ("ZIFT") procedures, embryo transport, egg harvesting (collection, storage, preparation), reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis (for example, determining sex) , other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered under the terms of the Policy; No legal obligation to pay - Services are excluded for Injuries and Illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health services and supplies furnished under or as part of a study, grant, or research program;

42) **Maternity Services** – Expenses incurred for any condition of or related to pregnancy, except complications arising from and unless specifically covered in the Schedule of Benefits. Also excluded are expenses associated with selective reduction during pregnancy.

43) **Maintenance Therapy** – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;

44) **Male Gynecomastia –** Those services and associated expenses for treatment of male gynecomastia.

45) **Massage Therapy – Those services and associated expenses related to massage therapy;**

46) **Medical complications** arising directly or indirectly from a non-Covered Service;

47) **Mental Health Services -** the diagnosis and treatment of all biologically based Mental Illnesses and psychiatric conditions, unless Covered by an attached Mental Health Substance Abuse Rider;

48) **Military Health Services** - Those services for treatment of military service-related disabilities when the Insured is legally entitled to other Coverage and for which facilities are reasonably available to the Insured; or those services for any Insured who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;

49) **Miscellaneous Service Charges** - Telephone consultations, document processing or copying fees, mailing costs, charges for completion of forms, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), any late payment charge, interest charges or other non-medical charges;

50) **Non-Prescription Drugs and Medications** - Over-the-counter ("OTC") drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

51) **Nutritional-based Therapy** - Nutritional-based therapies except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

52) **Newborn** home delivery and also the cost of child birth classes;

53) **Obesity Services** - Those services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature

54) **Occupational Injury** - Those services and associated expenses related to the treatment of an occupational Injury or Illness for which the Insured is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services under this Policy;

55) **Oral Surgery Supplies** - required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;

56) **Orthodontia** and related services;

57) **Orthotic Appliances, Repairs or Replacement** - The replacement costs for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated; also excluded are cranial (head) remodeling band for the treatment of postitional non-synostotic plagiocephaly; and other protective head gear;

56) **Over-the-counter supplies** such as ACE wraps, elastic supports, finger splints, Orthotics, and braces; also OTC products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

59) **Personal comfort and convenience** items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

60) **Prescription Drugs and Medications** - Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider.

61) **Private Duty Nursing** - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;

62) **Prosthetic Devices Repairs or Replacement** - The replacement costs for any otherwise Covered device, including replacement for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured;

62) **Private inpatient room**, unless Medically Necessary or if a Semi-private room is unavailable;

64) **Reduction or Augmentation Mammoplasty** - Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer;

65) **Reversal of Sterilization Services** - Those services and associated expenses related to reversal of voluntary sterilization;

66) **Sex Transformation Services** - Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;

67) **Sexual Dysfunction** - Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;

68) **Sleep Studies – Sleep studies provided within the home;**

69) **Smoking Cessation** - Those services and supplies for smoking cessation programs and treatment of nicotine addiction;

70) **Speech therapy** or voice training when prescribed for stuttering or hoarseness;

71) **Sports Related Services** - Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces and orthotics;

72) **Substance Abuse** diagnosis and treatment, unless Covered by an attached Mental Illness Substance Abuse Rider;

73) **Surrogate motherhood** services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of the Insured acting as a surrogate mother;

75) **Transplant Organ Removal** - Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not Covered under the Policy unless the recipient is the Insured and the donor's medical Coverage excludes reimbursement for organ harvesting;

76) **Transplant services**, screening tests, and any related conditions or complications related to organ donation when the Insured is donating organ or tissue to a person not Covered under the Policy;

77) **Transplant Services** and associated expenses involving temporary or permanent mechanical or animal organs;

78) **Travel Expenses** - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section;

79) **Treatment for disorders** relating to learning, motor skills and communication;

80) **Vision Aids, Associated Services** - Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;

81) **Vocational therapy**;

82) Health services resulting from **war or an act of war** when the Insured is outside of the continental United States; and

83) **Work hardening programs**.

Coordination of Benefits

This section describes how Benefits under this Policy will be coordinated with those of any other plan that provides Benefits to You.

The order of Benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the Benefits it pays, so that payment from all plans do not exceed 100% of the Plan's Allowable Expenses.

Definitions

A **Plan**, or "other plan" is any of those which provides Benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. In addition, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"Allowable Expense" means a health care service or expense including Deductibles and Copayments, that is Covered, at least in part by any of the Plans covering You or Your Covered Dependent. When a Plan provides benefits in the form of service (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not Covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are not the Plan's Allowable Expenses:

- If a Insured is Confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is otherwise a Covered benefit) is not an Allowable Expense.
- If a Insured is Covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If a Insured is Covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.
- The amount a benefit is reduced because a Insured does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

"Claim Determination Period" means a Benefit Year. However, it does not include any part of a year during which an Insured has no Coverage under the Plan, or before the date this COB provision or a similar provision takes effect.

"Closed Panel Plan" is a Plan that provides health benefits to Covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

"Joint Custody" If the specific terms of a court decree state that the parents shall share joint custody without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined below.

Order of Benefit Determination Rules

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

- The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
- A Plan that does not contain a COB provision that is consistent with this provision is always Primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical Coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type Coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.
- The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.
  - √ Non-Dependent or Dependent. The Plan that covers the Insured other than as a Dependent, for example as an employee, Insured, Subscriber or retiree is Primary and the Plan that covers the Insured as a Dependent is Secondary. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Insured as a Dependent; and Primary to the Plan covering the Insured as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Insured as an employee, Insured, Subscriber or retiree is Secondary and the other Plan is Primary.
  - √ Child Covered Under More Than One Plan. The order of benefits when a child is Covered by more than one Plan is:
    - The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
      - √ The parents are married;
      - √ The parents are not separated (whether or not they ever have been married); or
    - If both parents have the same birthday, the Plan that Covered either of the parents longer is Primary.
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care Coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
  - √ The Plan of the Custodial Parent;
  - √ The Plan of the spouse of the Custodial Parent;
  - √ The Plan of the non-custodial parent; and then
  - √ The Plan of the spouse of the non-custodial parent.

√ Active or inactive employee. The Plan that covers a Insured as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Insured is a dependent of a person Covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

√ Continuation coverage. If a Insured whose coverage is provided under a right of continuation provided by federal or state law also is Covered under another Plan, the Plan covering the Insured as an employee, Insured, Subscriber or retiree (or as that Insured's dependent) is Primary, and the continuation Coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

√ Longer or shorter length of coverage. The Plan that Covered the Insured as an employee, Insured, subscriber or retiree longer is Primary.

√ If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, the Plan will not pay more than the Plan would have paid had the Plan been Primary.

Effect On The Benefits of the Plan

- The Benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- The Benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision (whether or not claim is made) exceeds those Allowable Expenses in a claim determination period. In that case, the Benefits of this plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses. When the Benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

- Provide the Plan with information about other coverage and promptly notify the Plan of any coverage changes;
- Give the Plan the right to obtain information as needed from others to coordinate benefits;
- Return any excess amounts paid to you to the Plan if the Plan or Your Provider provides a credit or payment and later finds that the other Coverage should have been primary.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Agreement. If it does, the Plan may pay the amount to the organization that made the payment. The amount will then be treated as though it was a benefit paid under the Agreement. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payment made by the Plan, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the terms of the Agreement, the Plan may recover the excess payments from one (1) or more of:

- The persons it has paid; or
- For whom it has paid; or
- Insurance companies; or
- Other organizations.

Right of Reimbursement

In consideration of the coverage provided by this Policy, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - √ Providing any relevant information requested by Us,
  - √ Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - √ Responding to requests for information about any accident or injuries,
  - √ Making court appearances, and
  - √ Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;

- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

The Insured may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, the Insured or Authorized Representative may call or write the Plan to file a complaint or an appeal. We will consider all the facts and handle all complaints and appeals promptly and fairly.

Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this Policy.

Complaints

A complaint is an expression of dissatisfaction that may be resolved on an informal basis. Complaints may be expressed by telephone or in person and are handled by Our Customer Service Department. The Customer Service Department may involve one or more staff members of the Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.

Written Complaints will be acknowledged in writing by Plan within 5 working days after receipt of the Complaint. The Plan will conduct an investigation within 20 working days after receipt of the respective Complaint, unless the investigation cannot be completed within this time. If the investigation cannot be completed within the 20-day timeframe, the Insured will be notified in writing by the 20th working day of the specific reasons for the delay, and the investigation will be completed within 30 working days thereafter. The Insured will be notified of the resolution within five (5) working days after the investigation of the respective Complaint is completed. Within fifteen (15) working days after the investigation of the respective Complaint is completed, the person, if other than the Insured, who submitted the Complaint will be notified.

The address and telephone numbers for Complaints are:

Coventry Health & Life Insurance Company
P.O. Box 7109
London, KY 40742
Telephone: (800) 969-3343

Appeals

If the issue in dispute relates to an Adverse Benefit Determination and the Insured and/or the Authorized Representative are dissatisfied with resolution of the complaint or does not wish to first file a Complaint, he or she may file an Appeal. The Appeals must be made within 180 days of the Adverse Benefit Determination.

The address for the Appeals Department is:

Coventry Health & Life Insurance Company
Attn: Appeals Department
8320 Ward Parkway
Kansas City, MO 64114

You may ask Us to appoint a staff member to assist with the Appeal at any time during the process.

One level of internal Appeal is provided if You, or your Authorized Representative, disagree with an Adverse Benefit Determination. The Insured or Authorized Representative may file an Appeal by sending Us a letter describing the reason for the Appeal. For Appeals based in whole or in part on medical judgment, the Appeal Committee will include a Medical Director and/or a Physician designee who have no prior involvement in the case and who are not subordinates of the individual who rendered the Adverse Benefit Determination. If the Medical Director and/or Physician designee are not in the same or similar specialty of the case under review, the Committee will also consult a health care professional who has training and experience in that

field of medicine.

- § Appeals are concluded as follows:

  - √ Urgent Care Appeals –Urgent Care Appeals will be completed within 72 hours after receipt of the Appeal request. We will notify the Insured and/or Authorized Representatives verbally and provide a follow-up written notice within 24 hours after receipt of the Appeal request.
  - √ Pre-service Appeals – Requests for Pre-service Appeals will be acknowledged by letter within 5 working days of receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 15 calendar days of receipt of the Appeal request; however, with the Insured's permission, We may delay the resolution of the Appeal for 30 calendar days if We have not received adequate information.
  - √ Post-service Appeals – Requests for Post-service Appeals will be acknowledged by letter within 5 working days of receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 20 working days from the date of the request for a Appeal; however, with the Insured's permission, We may delay the resolution of the Appeal for 30 calendar days if We have not received adequate information.

The Insured will be notified of the resolution within five (5) working days after the investigation of the respective Appeal is completed. Within fifteen (15) working days after the investigation of the respective Appeal is completed, the person, if other than the Insured, who submitted the Appeal will be notified. Our written notification to the Insured or Authorized Representative will provide the reason for the decision. Our notice will give the Insured or Authorized Representative instructions on any additional Appeal Rights available.

Contact Information

You may contact your respective the Insurance Department at anytime by mail or telephone: Arkansas Department of Insurance, 1200 West Third Street, Little Rock, AR 72201, (501) 371 2600 or (800) 282-9134, and fax at (501) 371-2618, or via email at Insurance.Consumers@arkansas.gov.

General Provisions

Applicability

The provisions of this Policy shall apply to the Insured and all benefits and privileges shall be available to You .

Governing Law

This Policy is delivered and governed by the laws of the State of Arkansas for Arkansas residents.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of five (5) years after the time written proof of loss is required to be furnished.

You are encouraged to exhaust the Policy's Complaint and Grievance Procedures prior to pursuing legal action, (in a court or other government tribunal) as this may be the most expeditious and cost-effective method of resolving Your concerns.

Time Limit On Certain Defenses

After two years from the date of issue of this Policy no misstatements, except fraudulent misstatement, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

No claim for loss incurred or disability commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from Coverage by name or specific description effective on the date of loss has existed prior to the effective date of Coverage of this Policy.

Nontransferable

No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by the Plan under this Policy. Such right to health care service Coverage or other benefits is not transferable.

Relationship Among Parties Affected by this Policy

The relationship between the Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Plan, nor is the Plan or any employee of the Plan an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

You are not an agent or representative of the Plan, and shall not be liable for any acts or omissions of the Plan for the performance of services under this Policy.

Contractual Relationships

The Plan agrees to provide Coverage for services to the Insured, subject to the terms, conditions, exclusions and limitations of the Policy. This Policy is issued on the basis of the Insured's enrollment in the Plan, and the payment and the Plan's acceptance of the required Premium. The Plan has the right to increase Premium rates, provided the Insured is given thirty-one (31) days advance written notice.

Reservations and Alternatives

The Plan reserves the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein. The identity of the service providers and the nature of the services provided may be changed from time to time and without prior notice to or approval by the Insured. You must cooperate with those persons or entities in the performance of their responsibilities.

Severability

In the event that any provision of this Policy is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Policy, which shall continue in full force and effect in accordance with its remaining terms.

Entire Contract

No change in this Policy shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Policy and/or by Amendment to this Policy. Such Amendments will be incorporated into this Policy. Amendments to the Policy are effective upon thirty-one (31) days written notice to the Insured. No change will be made to the Policy unless made by an Amendment or a Rider that is issued by the Plan. No agent or representative has authority to change the Policy or to waive any of its provisions.

This Policy, including all matters incorporated, contains the entire agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained herein. This Policy, including the application agreement, and all endorsements, exhibits, addenda, or amendments, if any, supersedes all prior communications, representations, or agreements, either verbal or written, between the parties.

Waiver

The failure of the Plan or You to enforce any provision of this Policy shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Policy shall not be deemed or construed to be a waiver of such default.

Records

The Insured shall furnish the Plan with all medical information and proofs of previous Coverage that the Plan may reasonably require with regard to any matters pertaining to this Policy in the event the Plan is unable to obtain this information directly from the Provider or previous insurer.

By accepting Coverage under the Policy, the Insured, who has signed the application, authorizes and directs any person or institution that has provided services to the Insured, to furnish the Plan or any of the Plan’s designees at any reasonable time, upon its request, relevant information and records or copies of records relating to the services provided to the Insured. The Plan agrees that such information and records will be considered confidential. The Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning services which are necessary to implement and administer the terms of the Policy or for appropriate medical review or quality assessment.

Examination of the Insured

In the event of a question or dispute concerning Coverage for services, the Plan may reasonably require that a Participating Provider acceptable to the Plan examine the Insured at the Plan’s expense.

Payment of Claims

Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

Clerical Error

Clerical error shall not deprive any individual of Coverage under the Policy or create a right to additional benefits.

Workers' Compensation

The Coverage provided under this Policy does not substitute for and does not affect any requirements for Coverage by any Workers' Compensation Insurance law, occupational disease law or similar legislation.

Misrepresentation

Coventry Health Care of Kansas, Inc. will not provide coverage for any Insured who has knowingly concealed or misrepresented any material fact or circumstance relating to this Policy in connection with the presentation or settlement of a claim.

Conformity with Statutes

Any provision of this Policy which, on its Effective Date, is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes and regulations.

Non-Discrimination

In compliance with state and federal law, the Plan shall not discriminate on the basis of age, color, disability, gender, marital status, national origin, religion, sexual preference, or public assistance status.

Cancellation By Insured

The Insured may cancel this Policy at any time by written notice delivered or mailed to the Plan, effective upon receipt of such notice or on such late date as may be specified in such notice. In the event of cancellation or death of the Insured, the Plan will promptly return the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Important Numbers & Addresses

Customer Service / Claims Coventry Health & Life Insurance Company Customer Service PO Box 7109 London, KY 40742 (800) 969-3343 (866) 285-1864 TDD http://www.chckansas.com/	**Pre-Certification** Coventry Health & Life Insurance Company 8320 Ward Parkway Kansas City, MO 64114 (877) 837-8914
Appeals and Grievance Coventry Health & Life Insurance Company Attn: Appeals Department 8320 Ward Parkway Kansas City, MO 64114	**Arkansas Department of Insurance** 1200 West Third St Little Rock, AR 72201 (800) 282-9134 Insurance.Consumers@arkansas.gov

PRESCRIPTION DRUG RIDER

This Prescription Drug Rider ("Rider") is made a part of Coventry Health and Life Insurance Company's Individual Policy ("Policy"). The benefits provided by this Rider become effective on the date Coverage under the Policy is effective.

PRESCRIPTION DRUG BENEFITS

Subject to the terms, conditions and scope of coverage, including all Exclusions, Limitations and defined terms of the Policy unless otherwise provided in this Rider, [and] Insured Responsibility [and Ancillary Charges], outpatient Prescription Drugs will be Covered as listed below, when:

- Medically Necessary
- the Insured is eligible to receive Covered Services;
- written by a Prescribing Provider;
- [included on the Formulary]; and
- filled at a pharmacy.

[Generically equivalent pharmaceuticals will be dispensed whenever there is an FDA approved Formulary Generic drug.] [If you choose to receive a brand name Prescription Drug when a Formulary Generic Drug is available, You will be responsible for the] [Ancillary Charge] [and the] [Non-Formulary] [Formulary] [Insured Responsibility]. [The Ancillary Charge will be due regardless of whether or not the Prescribing Provider indicates that the pharmacy is to "Dispense as Written."] [Your total Insured Responsibility shall not exceed the] [average wholesale price ("AWP")] [total] [allowable] [cost] [of the Prescription Drug.]

Benefit[2] [3] [4]	**Insured Responsibility**		
	Participating Pharmacy	**Non-Participating Pharmacy**	**[Mail Order]**
[Deductible][and] [Coinsurance][2] [3] **([per Calendar Year] [per Contract Year] [per Benefit Year])**	[Individual:] [$0 - $15,000] [Family:] [$0 - $45,000] [The amount listed under the Schedule of Benefits]	[Individual:] [$0 - $30,000] [Family:] [$0 - $60,000] [The amount listed under the Schedule of Benefits]	[The amount listed under the Schedule of Benefits] [See applicable Participating or Non-Participating Pharmacy Insured Responsibility]
[Formulary] [Tier 1][A] [Prescription] Drugs [and] [Specialty Drugs]	[$0-$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [whichever is greater] [AD[1]] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)]	[$0-$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)]	[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]

[Formulary] [Tier 1][B] [Prescription Drugs] [and] [Specialty Drugs]	[$0-$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[$0-$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]
[Formulary] [Tier 2] [Prescription Drugs] [and] [Specialty Drugs]	[$0-$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[$0-$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]
[Non-Formulary] [Tier 3] [Prescription Drugs] [and] [Specialty Drugs]	[$0-$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[$0-$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]
[Formulary] [Diabetic Prescription Drugs, Supplies and Insulin]	[$0-$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[$0-$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD[1]] [[whichever is greater]up to a [$100-1,000] maximum per individual prescription] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]
[Formulary] [and] [Non-Formulary] [Tier 4] [Specialty Drugs]	[$0-$500] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[$0-$500] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD[1]] [whichever is greater] [up to a [$100-1,000] maximum per individual prescription] [Not Covered] [$0 - $30,000][Subject to the] [Coinsurance] [Out-of-Pocket] [2] [3] [Maximum (per [Benefit Year)] [amount listed under the Schedule of Benefits]	[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]

[Tier] [1][A][B][2][3][4] [Coinsurance] [Out-of-Pocket] [2] [3] **[Maximum (per [Benefit Year)]** *[includes [Copayments], [Coinsurance], and [Deductible]]*	[Individual:][$0 - $30,000] [Family:] [$0 - $60,000] [The amount listed under the Schedule of Benefits]	[Individual:] [$0 - $30,000] [Family:] [$0 - $60,000] [The amount listed under the Schedule of Benefits]]	[The amount listed under the Schedule of Benefits]] [See applicable Participating or Non-Participating Pharmacy Insured Responsibility]

[Benefit Maximums]	
[Benefit Year Benefit Maximum] [3] • **[Prescription Drugs]** • **[Specialty Drugs]**	[Individual:] [$1,000 - Unlimited] [Family:] [$1,000 - Unlimited] [The amount listed under the Schedule of Benefits] [Individual:] [$1,000 - Unlimited] [Family:] [$1,000 - Unlimited] [The amount listed under the Schedule of Benefits]
[Lifetime Benefit Maximum] [3]	[$1,000,000 – Unlimited] [The amount listed under the Schedule of Benefits]

1. [AD means After Deductible. The [coinsurance] [and] [copayment] requirement applies after You have satisfied the [annual] Deductible requirement.]
2. [Copayments] [,] [Deductible] [and] [Ancillary Charges] [do not] apply to the [Out-of-Pocket] [Coinsurance] [Maximum listed on the Schedule of Benefits.]
3. [Copayments] [,] [Deductible] [and] [,] Ancillary Charges] [,] [Benefit Maximum] [,] [and] [Lifetime Maximum] [do not] [apply to the] [Lifetime] [and] [Benefit Year] [Maximum listed on the Schedule of Benefits].
4. To find Your Prescription Drug, its applicable Tier and any Pre-Certification requirements, visit Our serachable Formulary on Our website [www.chckansas.com], in the Participating Provider's office, or by contacting the Customer Service Department.

The following also apply:

- Insured Responsibility is due each time a prescription is filled or refilled, up to a thirty-one (31) day supply for Retail and Specialty Pharmacy, and up to a ninety-three (93) day supply for Mail Order Pharmacy.
- [Select over-the-counter medications as determined by the Plan in an equivalent prescription dosage strength will be covered under this Rider for the [Tier 1][A][B] [Formulary] [Non-Formulary] [appropriate] Insured Responsibility. Coverage of the selected over-the-counter medications requires a physician prescription.]
- Only one drug and "Rx Unit" will be dispensed per prescription. The Rx Unit quantity is determined by FDA labeling, the dosage required or the Plan Formulary guidelines. Please note: Insured Responsibility is required for each Rx Unit, container, or prepackaged item.
- If a Prescription Drug covered is prescribed in a single dosage amount for which the particular prescription drug is not manufactured in such single dosage amount and requires dispensing the particular prescription drug in a combination of different manufactured dosage amounts, the Insured Responsibility will be the same as if the Prescription Drug was manufactured in such single dose.
- Insureds presently taking a prescription drug shall be notified either electronically, or in writing (upon request of the enrollee), at least thirty (30) days prior to any deletions to the Formulary. Notifications will not be provided for Generic substitutions.

- [Value Formulary drugs are offered at no Insured Responsibility on a **temporary basis** to Insureds that are on or have recently received certain drugs(s) and/or receive a new prescription for certain drug(s), as designated by the Plan to promote effective and efficient use of the Plan drug benefits. These drugs are listed in an addendum to the Formulary, which may be found on the our website at [www.chckansas.com]. The formulary addendum shall also identify the Plan Criteria applicable to the Value Formulary Drugs. **This formulary addendum may change from time to time without prior notice.** Insureds that appear to meet the Plan criteria for Value Formulary Drugs (as such information is available in Plan's claims records) will be notified if they qualify for a Value Formulary drug, when such drugs are temporarily added. Please note, just because a Insured fills a prescription for a Value Formulary drug does not qualify him/her to receive such drug at no Insured Responsibility. Rather, only Insureds that meet Plan criteria will receive the selected drug at no Insured Responsibility. If a Insured does not satisfy the Value Formulary drug Plan criteria, the drug shall be subject to its applicable Insured Responsibility]

DEFINITIONS

Any capitalized terms used in this Rider and not otherwise defined herein shall have the meaning set forth in the COC. The following definitions apply to this Rider:

[Ancillary Charge. A charge in addition to the Insured Responsibility You are required to pay for a Prescription Drug which, through Your request or that of the Prescribing Provider, has been dispensed by the brand name, even though a [Formulary] Generic is available. The Ancillary Charge, if any, shall be the difference between the Plan's contracted price for the Non-Formulary or Formulary brand name drug and the contracted price of the generic drug.. The Ancillary charge will be in addition to the appropriate Insured Responsibility. You are responsible at the time of service for payment of the Ancillary Charge directly to the Pharmacy. The Ancillary Charge is not a Covered charge and does not apply to an Deductible, Coinsurance, or Out-of-Pocket Maximum.]

[Coinsurance. The amount in which the Insured pays a specified percentage of the cost for a Covered Service.] [You are responsible at the time of service for payment of the Coinsurance directly to the Pharmacy.]

[Copayment. The amount You will be charged by the Pharmacy to dispense or refill any Prescription.] [You are responsible at the time of service for payment of the Copayment directly to the Pharmacy.]

[Deductible. The amount, which must be satisfied each Benefit Year, before benefits subject to the Deductible are payable under this Rider. [You are responsible at the time of service for payment of the Prescription directly to the Pharmacy, until your Deductible is met.]

Formulary. A list of specific generic and brand name Prescription [and Specialty] Drugs Authorized by the Plan, and subject to periodic review and modification at least annually by the Plan's Pharmacy and Therapeutics Committee. The Formulary is available for review in the searchable Formulary on Our website, [www.chckansas.com], in the Participating Provider's office, or by contacting the Customer Service Department. Please note: Inclusion of a drug within the Formulary does not guarantee that Your health care provider will prescribe that drug for a particular medical condition or illness.

Formulary Prescription Drug. A Prescription [and Specialty] Drug that appears on the Plan's Formulary.

Generic Prescription Drug. A Prescription Drug as being prescribed by its generic and chemical name heading according to the principal ingredient(s) and approved by the Food and Drug Administration.

Mail Order Pharmacy. A Pharmacy that dispenses Maintenance Medications pursuant to a 93 day/cycle supply. Prescription Drugs determined by the Plan to be Maintenance Medications on the Formulary and prescribed by a Prescribing Provider can be filled by mail order.

Maintenance Medication(s). A medication that is listed and identified on the Formulary as a maintenance prescription.

Insured Responsibility. The dollar amount detailed under Prescription Drug Benefits which must be paid by You to a Pharmacy providing a Prescription Drug covered by this Rider.

Non-Formulary Prescription Drug. A Prescription Drug that is not on the Plan's list of Formulary Prescription Drugs.

Non-Participating Pharmacy. Any pharmacy that is not a Participating Pharmacy as defined herein. [A Prescription Order or Refill may be obtained through a Non-Participating Pharmacy, however, You may be required to pay for the cost of the Prescription Drug(s) and file a claim for reimbursement.]

Participating Pharmacy. A pharmacy licensed in the State in which it is located that has entered into a written contract with the Plan to provide services to the Plan's Insureds, or on whose behalf a written contract has been made with the Plan which is in effect at the time services are provided.

[Pre-Certification. Some drugs require Pre-Certification in order for them to be Covered Services. Drugs requiring Pre-Certification are identified within the Formulary with "PA" next to the name of the drug.]

Prescribing Provider. Any person holding the degree of Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Medicine, or Doctor of Dental Surgery or any other provider who is duly licensed in the United States to prescribe medications in the ordinary course of his or her professional practice.

Prescription Drug(s). Any medication or drug which:

- is provided for outpatient administration;
- has been approved by the Food and Drug Administration; and
- under federal or state law, is dispensed pursuant to a prescription order (legend drug).

This definition of Prescription Drug may include some over-the-counter medications or disposable medical supplies (e.g., insulin and diabetic supplies), psychotherapeutic drugs used for treatment of mental illness, other than when administered in a hospital or provider's office, and a compound substance when it meets the Plan's criteria and the product is not available commercially.

Prescription Order or Refill. The authorization for a legend Prescription Drug issued by a Prescribing Provider who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

Retail Pharmacy. Prescription Drugs prescribed by a Prescribing Provider and obtained through a Pharmacy.

Specialty Drug. Those drugs listed on the Specialty Drug Formulary and identified with an "SP". Specialty Drugs are typically used to treat rare or complex disease. These drugs frequently require special handling, close clinical monitoring and management and Pre-Certification prior to being dispensed.

Specialty Pharmacy. A pharmacy that is designated as a Specialty Pharmacy by the Plan for Specialty Drug Prescription Orders or Refills.

[Step Therapy. A process where the Plan or its designee determines that a Prescription Order or Refill based upon information provided by the Prescribing Provider, the Prescription Order or Refill satisfies the Pre-Certification requirements for Coverage. Certification must be obtained prior to dispensing.]

LIMITATIONS

1. Authorized refills will not be provided after the lesser of:
   i. twelve (12) months from the original date on the prescription order; or
   ii. the period of time limited by state or federal law.

2. [Contraceptive diaphragms prescribed by a Prescribing Provider are limited to two (2) per year.]

3. [Coverage of injectable drugs is limited to [Specialty Drugs as determined by the Plan] [and] insulin, [glucagon], [bee sting kits], [Imitrex] [and] [injectable contraceptives] that are commonly and customarily administered by the Insured.]

4. Selected products, as defined by the plan, with narrow therapeutic index, potential for misuse and/or abuse, high cost, or a narrow or limited range of Food and Drug Administration approved indications may require Pre-Certification.

5. The Pharmacy shall not dispense a Prescription Drug order which, in the Pharmacist's professional judgment, should not be filled.

6. To promote appropriate utilization, or following manufacturer's recommendations, certain plan approved medications may have a quantity limit on the amount of medication dispensed and pre-certification must be obtained prior to dispensing.

7. We reserve the right to include only one dosage or form of a drug on our Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc) from the same or different manufacturers. The product, in the dosage or form, that is listed on the Formulary will be Covered at the applicable Insured Responsibility. The drug, product or products, in different forms or dosages or from the same or different manufacturers, not listed on the Formulary will be [excluded from coverage] [subject to Tier 3].

8. Coverage of Prescription Drugs, therapeutic devices or supplies requiring a Prescription Order and prescribed by a Prescribing Provider is limited to Plan approved drugs, devices, supplies, or spacers for metered dose inhalers.

9. [Coverage through the Mail Order Pharmacy is not available on drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the Plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances or anticoagulants.]

10. [When You use a Non-Participating Prescribing Provider, it is Your responsibility to contact the Plan before a Prescription Order or Refill is filled to obtain any required Pre-Certification. If the Plan is not contacted for Pre-Certification, You will be required to pay one hundred percent (100%) of the cost for a Prescription Drug.]

EXCLUSIONS

The following are **Excluded** from Coverage under this Rider:

1. Prescription Drugs related to the treatment of a Non-Covered Service (i.e. dental services).

2. Prescription Drugs that are not Medically Necessary. The Plan reserves the right to require medical Pre-Certification for selected drugs before providing Coverage.

3. Prescription Drugs that are Experimental or Investigational, including those labeled "Caution-limited by Federal Law to Investigational Use," FDA approved drugs used for investigational indications or at investigational doses and drugs found by the FDA to be ineffective or given as a part of a study.

4. Products not approved by the FDA, Prescription Drugs with no FDA approved indications, and DESI Drugs. This exclusion shall not apply to a drug, medicine or medication that is recognized for the treatment of cancer in one of the standard reference compendia or in substantially accepted peer-review medical literature.

5. Any Prescription Drug which is to be administered, in whole or in part, while You are in a hospital, medical office or other health care facility.

6. Compounded prescriptions [are excluded unless all of the following apply:
   a. there is no suitable commercially-available alternative available;
   b. the main active ingredient is a Covered Prescription Drug;
   c. the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Prescribing Provider; and
   d. the claim is submitted electronically by the Pharmacy.]

7. Vitamins and minerals (both over-the-counter and legend), except as specified on the Formulary.

8. [Injectable medications] [and] [Specialty Drugs], [except those designated by the Plan.]

9. Drugs that do not require a prescription by federal or state law, that is, over-the-counter drugs or over-the-counter products, unless specifically designated for Coverage by the Plan or the Formulary list and obtained from the Pharmacy with a Prescription Order or Refill. Also excluded are Prescription medications that are not for treatment of illness, injury, or have an over-the-counter equivalent, unless otherwise specified on the Formulary.

10. Devices or supplies of any type, even though requiring a Prescription Order, such as but not limited to, therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, syringes or other devices, regardless of their intended use, unless otherwise specified as a Covered benefit in this Rider.

11. [Contraceptive implant systems], [and] [prescription] [or] [nonprescription contraceptive devices (e.g., condoms[,] [and] spermicidal agents[, and Norplant]).]

12. [Extemporaneous dosage forms of natural estrogen or progesterone; or any natural hormone replacement product, including but not limited to oral capsules, suppositories, creams and troches.]

13. [Prescription Drugs used for the treatment of impotence.]

14. [Anti-smoking medication or smoking cessation devices.]

15. [Prescription Drugs used to treat chemical dependency and/or substance abuse.]

16. [Drugs used primarily for hair restoration.]

17. [Pharmacological therapy for weight reduction, dietary supplements, appetite suppressants, and other drugs used to treat obesity, morbid obesity or assist in weight reduction.]

18. [Drugs, oral or injectable, used for the primary purpose of, or in connection with, treating infertility, fertilization, and/or artificial insemination.]

19. Medications used for cosmetic purposes or to enhance work or athletic performance (i.e. Nuvigil or Provigil for shift work, anabolic steroids and minoxidil lotion, retin A (tretinoin) for aging skin). Also excluded are drugs, oral or injectable, used to slow or reverse normal aging processes (i.e. growth hormone, testosterone, etc.).

20. Prescription Drugs dispensed in unit doses, when bulk packaging is available, or repackaged Prescription Drugs.

21. Replacement for lost, destroyed or stolen prescriptions.

22. Duplicate drug therapy (i.e. two antihistamine drugs).

23. Oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the Formulary.

24. Prescriptions that You are entitled to receive without charge under any Workers' Compensation law, occupational statute, or any law, or regulation of similar purpose.

25. [Tier 2] [and] [,] [Tier 3] [and] [,] [Tier 4] [and] [Non-Formulary drugs, devices and supplies]; [unless otherwise defined in this Rider.]

CONDITIONS

1. The Plan and its designees shall have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of this Rider or for appropriate medical/pharmaceutical review or quality assessment.

2. The Plan shall not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of drugs) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug whether or not Covered under this Rider.

GENERAL PROVISIONS

1. Your Coverage under this Rider will end when Coverage under the COC ends.

2. Nothing herein shall be held to vary, alter, waive, or extend any of the definitions, terms, conditions, provisions, agreements or limitations of the COC, other than as stated above.

3. Discounts and Rebates. Insured understands and agrees that Health Plan may receive a retrospective discount or rebate from a Network Provider or vendor related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by Health Plan and its affiliates. Insured shall not share in such retrospective volume-based discounts or rebates. However, such rebates will be considered, in the aggregate, in Health Plan's prospective premium calculations.

[Signature of Company Officer]
[Title of Company Officer]

CoventryOne. Underwritten by Coventry Health and Life Company and administered by [Coventry Health Care of Kansas, Inc.]	PPO Schedule of Benefits [Plan Name] State(s) of Issue: Arkansas	
Benefit	**Insured Responsibility**	
	Participating Providers	**Non-Participating Providers[2]**
[Policy Deductible[4]] ([per Calendar Year] [per Contract Year] [Benefit Year]	[Individual:] [$0 - $15,000] [Family:] [$0 - $45,000]	[Individual:] [$0 - $30,000] [Family:] [$0 - $60,000]
[Coinsurance] [and] [Copayment] For All Eligible Expenses (unless otherwise noted)	[$0-$200] [Copayment] [and] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [0%-70%] [Coinsurance] [AD[3]]
[Coinsurance] [Out-of-Pocket[4]] Maximum [(per [Calendar Year] [Contract Year] [Benefit Year])]	Individual: [$0 - $30,000] Family: [$0 - $60,000]	Individual: [$0 - $30,000] Family: [$0 - $60,000]
Physician Office Services[1]		
§ Primary Care Physician Office Visit[1]	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Specialist Physician Office Visit[1]	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ X-ray & Laboratory Services	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Allergy Injections	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ All Other Covered Services - Including but not limited to: Allergy Testing, Therapeutic Injections, Office Surgery	[Same as Physician Office Visit[1]] [$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[Same as Physician Office Visit[1]] [$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Preventive Care		
§ Preventive Care – Including all Preventive Services described in the Covered Services Section of the CoventryOne Policy.	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Immunizations-Adult	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]

§ Immunizations-Pediatric (Up to age 72 months)	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Mammogram [Diagnostic] [and] Routine Screening	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Colonoscopy [Diagnostic] [and] Routine Screening	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Outpatient Laboratory Services		
§ In a Physician's Office	[Same as Physician Office Visit[1]] [$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[Same as Physician Office Visit[1]] [$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ At a Free Standing Facility	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ At a Hospital Facility	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Outpatient Services At Hospital or Free Standing Facility		
§ Radiology	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Diagnostic Services	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Dialysis	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]]*

§ Surgery and Scopes	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year']*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Inpatient Hospital Care		
§ Inpatient hospital care, including semi-private room & board, intensive/coronary care, [maternity care,] x-ray, laboratory, professional services and other facility & ancillary charges.	[$0-$2,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-4,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ Inpatient Rehabilitation *[Limited to [10 – 200] days per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-4,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Urgent Care and Emergency Care Services		
§ Ambulance/Emergency Transportation (Ground or Air)	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*

§ At an Urgent Care Center	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ At a Hospital Emergency Room [(Copayment waived if admitted)]	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ [Emergency Room] [Related Professional Fees]	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Short Term Therapies		
§ Physical Therapy, Occupational Therapy & Speech Therapy *[Limited to [10 – 200] visits [per Therapy] per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ Cardiac and Pulmonary Rehabilitation *[Limited to [10 – 200] visits per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*

§ Partial Day Programs (4 hours or greater) *[Limited to [10 – 200] Visits per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ Chiropractic Services/Spinal Manipulation *[Limited to [4 – 200] Visits per [Calendar Year] [Contract Year] [Benefit Year]]*	[Same as Specialist Physician Office Visit] [$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[Same as Specialist Physician Office Visit] [$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Other Services		
[Eye Exam] [including refraction] *[Refraction Services Limited to [1 – 6] exams every [12 – 48] Months]*	[Same as Physician Office Visit[1]] [$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[Same as Physician Office Visit[1]] [$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Injectable Medications (Not listed elsewhere)	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Skilled Nursing Facility *[Limited to [10 – 200] days per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*

Home Health Care *[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Hospice § [Inpatient] *[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]* § [Outpatient] *[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Durable Medical Equipment § The cost of Phenylketonuria (PKU) or any other Amino and Organic Acid Inherited Disease Food when the food and food products exceeds the income tax credit of $2,400.	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Prosthetics & Braces	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Organ / Tissue Transplant *[Services provided at approved Coventry Transplant Centers] [only]*	See Appropriate Benefit	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]* *[See Appropriate Benefit]*

Please Note: Maximum Benefit Limits do not guarantee that all services will be approved to the Maximum number allowed under this plan. Coinsurance is based on the contracted allowed amount reimbursed to the provider, if applicable.

In order to receive the maximum benefits, it is Your obligation to ensure that any required Pre-Certification has been obtained. Please see the Pre-Certification requirements outlined in your Certificate of Coverage. [***Failure to do so may result in a [10 - 50%] reduction in benefits [,up to a maximum of [$100 – 500],] for that particular service.]***

1. Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP benefit will apply. If you receive this service from a Specialist, your Specialist benefit will apply.

2. When receiving services from non-participating providers, payment for Covered Services is limited to the lesser of the billed charge or the Out-of-Network rate less applicable Copayment, Coinsurance and/or Deductibles. Please refer to the Certificate of Coverage for additional details.

3. [AD means After Deductible. The [coinsurance] [and] [copayment] requirement applies after You have satisfied the Deductible requirement.]

4. [If you have individual-only coverage, you must satisfy the individual deductible and/or out of pocket maximum before any benefits will be paid. If two or more family members are on the same policy, you must satisfy the entire family deductible and/or out of pocket maximum before any benefits will be paid.]

MEDICAL EXCLUSION RIDER

The Medical Exclusion Rider ("Rider") is underwritten by Coventry Health and Life Insurance company and administered by [Coventry Health Care of Kansas, Inc.] This Rider ("Rider") is incorporated into Individual Policy for the following Insured(s).

[INSUREDS NAMES]

This Rider is a permanent amendment to the Individual Policy to which it is attached. All definitions, provisions, terms, Limitations, Exclusions, and conditions of the Individual Policy apply to this Rider except to the extent such terms and conditions are explicitly superseded or modified by this Rider.

The Effective Date of this Rider shall be consistent with the Effective Date of Your Individual Policy.

The Individual Policy is hereby amended to exclude Coverage for any equipment, supply, service, surgery, diagnostic procedure, evaluation, prescription drug delivered under the medical benefit, [prescription drug delivered under any pharmacy benefit], therapy, and/or treatment of any kind for the following:

[**Cervical Spine:** Any injury to, disease or disorder of the cervical spine, including but not limited to the vertebrae, intervertebral discs, surrounding ligaments and muscles, lumbosacral and sacroiliac articulations, complicating sciatic neuritits, radiculitis, and any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Thoracic Spine:** Any injury to, disease or disorder of the thoracic spine, including but not limited to the vertebrae, intervertebral discs, surrounding ligaments and muscles, lumbosacral and sacroiliac articulations, complicating sciatic neuritits, radiculitis, and any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Lumbo-Sacral Spine:** Any injury to, disease or disorder of the lumbo-sacral spine, including but not limited to the vertebrae, intervertebral discs, surrounding ligaments and muscles, lumbosacral and sacroiliac articulations, complicating sciatic neuritits, radiculitis, and any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Apnea, Sleep Apnea:** Any diagnostic study, treatment or testing for, [medications for], or operation for or any complications resulting from but not limited to, sleep apnea, obstructive apnea, central apnea, hypopneas.]

[**Knees, Both:** Any injury to, disease or disorder of both knees, including but not limited to the associated bones, tendons and ligaments including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Knee, Right:** Any injury to, disease or disorder of the right knee, including but not limited to the associated bones, tendons and ligaments including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Knee, Left:** Any injury to, disease or disorder of the left knee, including but not limited to the associated bones, tendons and ligaments including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Hiatal Hernia:** Hiatal hernia, including but not limited to any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Heart Burn, Acid Reflux, GERD, Esophagitis:** Heart burn, acid reflux, GERD (Gastro Esophageal Reflux Disease), Barrett's Esophagitis disease or disorder of the esophagus, esophageal sphincter, and stomach including but not limited to any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Cataracts, Both Eyes:** Cataracts of both eyes, including but not limited to any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Cataracts, Right Eye:** Cataracts of the right eye, including but not limited to any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Cataracts, Left Eye:** Cataracts of the left eye, including but not limited to any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Diverticulitis and Diverticulosis:** Diverticulitis and Diverticulosis of the small intestine, large intestine and colon including but not limited to any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Thyroid:** Any disease or disorder of the thyroid gland including but not limited to; Goiter, Hyperthyroidism, Hypothyroidism, and thyroiditis and any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Nasal/Sinus/Deviated Septum:** Any disease or disorder of the sinuses, nasopharyngeal tract, and accessory sinuses, including but not limited to sinusitis, nasal polyp(s), and deviated septum and any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Hips, Both:** Any disease, injury or disorder of both hips and the associated bones, tendons and ligaments including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Hip, Right:** Any disease, injury or disorder of the right hip and the associated bones, tendons and ligaments including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Hip, Left:** Any disease, injury or disorder of the left hip and the associated bones, tendons and ligaments including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Kidneys, Both:** Any disease or disorder of both kidneys or urinary tract, including kidney stones, and renal failure, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Kidney, Right:** Any disease or disorder of the right kidney or urinary tract, including kidney stones, and renal failure, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Kidney, Left:** Any disease or disorder of the left kidney or urinary tract, including kidney stones, and renal failure, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Internal Fixation of Bones:** Any internal fixation of bones (for example; pins, screws, plates and braces) including the insertion of, removal of, any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Headaches and Migraine Headaches:** Headaches and migraine headaches, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Varicose Veins:** Varicose veins, varicose or stasis ulcer, phlebitis, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Tendonitis, Bursitis:** Tendonitis, bursitis, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Bilateral Carpal Tunnel Syndrome:** Carpal Tunnel Syndrome of both wrists, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Right Carpal Tunnel Syndrome:** Carpal Tunnel Syndrome of the right wrist, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Left Carpal Tunnel Syndrome:** Carpal Tunnel Syndrome of the left wrist, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

[**Temporomandibular Joint (TMJ):** Any misalignment of the upper or lower teeth and/or improper positioning of how the jaw bone connects to the skull, including temporomandibular joint, its associated tendons, ligaments, musculature, including any treatment or testing for, [medications for], or operation for or any complications thereof.]

All other terms and conditions of the Individual Policy which this Rider amends remain in full force and effect.

[Signature of Company Officer]

TMJ RIDER

This Musculoskeletal Disorders of the Face, Neck or Head Rider ("Rider") is underwritten by Coventry Health and Life Insurance company and administered by [Coventry Health Care of Kansas, Inc.] and is made a part of Coventry Health and Life Insurance Company's Policy. The benefits provided by this Rider become effective on the date Coverage under the Policy is effective.

DEFINITIONS

All definitions of the Policy to which this Rider is attached shall apply except to the extent such terms are explicitly superseded or modified by this Rider.

BENEFITS

Coverage is provided for medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures. This coverage shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology whether prescribed or administered by a physician or dentist, subject to the applicable benefits on the Schedule of Benefits.

GENERAL PROVISIONS

1. Your Coverage under this Rider will end when Coverage under the Policy ends.

2. Nothing herein shall be held to vary, alter, waive, or extend any of the definitions, terms, conditions, provisions, agreements or limitations of the Policy, other than as stated above.

[Signature of Company Officer]

MENTAL HEALTH SUBSTANCE USE RIDER

This Mental Health Substance Use Rider ("Rider") is underwritten by Coventry Health and Life Insurance company and administered by [Coventry Health Care of Kansas, Inc]. and is made a part of Coventry Health and Life Insurance Company's Policy. The benefits provided by this Rider become effective on the date Coverage under the Policy is effective.

MENTAL HEALTH SUBSTANCE USE BENEFITS

Subject to the terms, conditions and scope of coverage, including all Exclusions, Limitations and defined terms of the Policy unless otherwise provided in this Endorsement, recognized Mental Illness Substance Abuse benefits will be provided under this endorsement as follows:

- Inpatient treatment in a Hospital or Residential Treatment Facility, including the services of mental health professionals, is subject to the applicable Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Schedule of Benefits.
- Outpatient treatment, including treatment through partial or full-Day Program Services, is subject to the applicable Deductible, Copayment and/or Coinsurance for services as listed in the Schedule of Benefits.

The Plan contracts with an outside vendor to coordinate and determine Medical Necessity of the diagnosis and treatment of all biologically based Mental Illnesses, psychiatric conditions, and Substance Abuse.

If You have any questions about Your Mental Health and Substance Abuse Coverage, the appropriate way to access Coverage, or to Pre-Certify care for Mental Health and Substance Abuse, you must contact the contracted vendor. The vendor's name and telephone number are listed on the back of Your ID card, in the Directory of Health Care Providers, Important Numbers and Addresses.

DEFINITIONS

Terms that are capitalized herein have the following definitions:

Day Program Services: A structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization.

Nonresidential Treatment Program: A program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting.

Recognized Mental Illness(es): mental illness, alcoholism, drug abuse or substance use disorders specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric..

Residential Treatment Facility: A facility licensed by the applicable state or approved by the Joint Commission on Accreditation of Health Care Organizations. The Residential Treatment Facility may be a general community Hospital with approved mental health beds, a psychiatric Hospital, a facility for the chemically dependent, or a Community Mental Health Center.

Residential Treatment Program: A program certified by the department of mental health involving residential care and structured, intensive treatment.

LIMITATIONS AND EXCLUSIONS
The following types of treatment are excluded in addition to the Exclusions and Limitations in the Policy:

- Services rendered or billed by a school or halfway house.

IMPORTANT NUMBERS & ADDRESSES

[MHNet Behavioral Health
PO Box 209010
Austin, TX 78720
(866) 607-5970

http://www.chckansas.com/]

[Signature of Company Officer]

HEARING AID RIDER

This Hearing Aid Rider ("Rider") is underwritten by Coventry Health and Life Insurance company and administered by [Coventry Health Care of Kansas, Inc.] and is made a part of Coventry Health and Life Insurance Company's Policy. The benefits provided by this Rider become effective on the date Coverage under the Policy is effective.

DEFINITIONS

All definitions of the Policy to which this Rider is attached shall apply except to the extent such terms are explicitly superseded or modified by this Rider.

"Hearing Aid"

An instrument or device, including repair and replacement parts, that is designed and offered for the purpose of aiding persons with or compensating for impaired hearing, is worn in or on the body; and is generally not useful to a person in the absence of a hearing impairment.

BENEFITS

Coverage is provided for medical treatment of Hearing Aids when medically appropriate and when dispensed by an approved provider. Coverage is limited to one hearing aid per ear in a three year period and is not subject to any Policy deductible or copayment.

GENERAL PROVISIONS

1. Your Coverage under this Rider will end when Coverage under the Policy ends.

2. Nothing herein shall be held to vary, alter, waive, or extend any of the definitions, terms, conditions, provisions, agreements or limitations of the Policy, other than as stated above.

[Signature of Company Officer]

CoventryOne. Underwritten by Coventry Health and Life Insurance Company

[CoventryOne]
Received Date: _______________

[Submit completed Application for Health Coverage to:]
[address/fax]

[Special State or Association Name]

Application for Health Coverage

Important: [Please print clearly in BLACK ink as instructed in each section. Initial and date corrections (correction fluid is not permitted)]. Read and sign the [Acknowledgements] [and] [Authorization of Release of Information] [section].

Check all that apply:

☐ New Application [☐ Add a Dependent] [☐ Guarantee Issue] [☐ Plan Benefits Increase]

[Plan Choice

Choose one (1) plan only. [If other individuals applying for coverage wish to apply for different plans, a separate Application must be used.]

[Plan Category]	[Plan Category]	[Plan Category]	[QHDHP Plans]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]

[Maternity benefits for this plan begin twelve (12) months from the effective date of the policy.]

[If you have selected a Coventry*One* Qualified High-Deductible Health Plan (QHDHP), you are eligible to open a Health Savings Account (HSA) through our HSA trustee, Health Equity, upon approval. [Through HealthEquity, you will be subject to an account activation fee of [$1 - $30] [and] [monthly account maintenance fees of [$1 - $10] may apply].

[☐ I elect to have an HSA opened through HealthEquity]

Optional Rider Offerings: The below riders are optional. To elect any or all coverage, please indicate by placing an 'x' through the coverage(s) you wish to purchase. Please note that additional premium will apply.

☐ Temporomandibular Joint (TMJ) and Craniomandibular Disease
☐ Mental Health Substance Abuse
☐ Hearing Aids

Requested Effective Date: [☐ Day of Coventry*One* Approval] [OR] [☐ ___ / ___ / 20 ___] [OR] [1st or 15th] [day of ________20_____]

Requested Effective Date must be after, but no MORE than sixty days past the signature date of the Application. Requested Effective Date is not guaranteed.

Amount quoted for Requested Effective Date: $_________ / Month [☐ Individual ☐ Family]

[Note: The amount quoted is an estimated cost of the selected health plan, which is subject to change based on medical history, the underwriting process, and, if any, other relevant factors.]

Primary Applicant Information

Please provide information on the Primary Applicant.

[Agent Name: ___________________________________]

Last name	First name			MI	Primary phone number ( ) -
Home address	City	State	ZIP	[County]	
Mailing address *(If different from address above)*	City	State	ZIP	Best time and phone number to receive a call regarding this Application, if necessary: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime (8am-8pm) ( ) -	
E-mail address *(if we may correspond with you via E-mail)*	☐ [Check here to consent to receiving your policy and other pertinent documents by email only]				
[Relationship]	[Occupation / Title]				

Applicant and Dependent Information

General Information List all individuals applying for health coverage in this section. If you need more space, attach a separate sheet of paper with the details in the same format as the box below. Sign and date any attachments.

	Full Name (Last, First, MI)	**Social Security Number**	**Birthdate** (mm/dd/yyyy)	**Gender** (M or F)	**Height** (ft. in.)	**Weight** (lbs.)	**Tobacco use in past 12 months?[1]**	**U.S. residency [2]**
1	Primary Applicant						☐ Yes ☐ No	☐ Yes ☐ No
2	Spouse						☐ Yes ☐ No	☐ Yes ☐ No
		Home address (if different from Primary Applicant)						
3	Dependent Child						☐ Yes ☐ No	☐ Yes ☐ No
		Home address (if different from Primary Applicant)						
4	Additional Child						☐ Yes ☐ No	☐ Yes ☐ No
		Home address (if different from Primary Applicant)						
5	Additional Child						☐ Yes ☐ No	☐ Yes ☐ No
		Home address (if different from Primary Applicant)						
6	Additional Child						☐ Yes ☐ No	☐ Yes ☐ No
		Home address (if different from Primary Applicant)						

[1 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months]. 2 ['U.S. residency' refers to the designated individual living legally in the United States for the past [6-24] months].

1 Prior Insurance Coverage	
Has any individual applying for coverage had any health insurance coverage in the past 2 years? If "Yes," list names, start and end dates below. _____	**☐ Yes ☐ No**
2 [Pre-Existing Condition Credit]	

[Applicant Name: _____] **[Agent Name: _____]**

[Does any individual applying for coverage have proof of prior creditable coverage without a break in coverage of 63 days or more and would like to use it to credit any pre-existing condition limitation? If "Yes," you must include a copy of the [creditable coverage document(s) / Certificate of Creditable Coverage]. [You may be subject to a pre-existing condition exclusion until Coventry*One* receives these documents.]	☐ **Yes** ☐ **No**

3 [HIPAA Guarantee Issue Coverage]

[**If you have answered "Yes" to the above Pre-Existing Condition Credit question, you may be HIPAA eligible and may have the right to obtain certain individual health policies on a guaranteed issue basis and without application of any pre-existing condition exclusions or limitations. You must meet the following criteria:**

- You must have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage, other than coverage under a short-term health insurance policy, must have been under a group health plan, governmental plan, church plan or other health insurance coverage offered in connection with any such plan;
- Your coverage must not have been terminated because of fraud or failure to pay premiums;
- You must have exhausted COBRA continuation coverage or continuation under a similar state provision;
- You must not be eligible for a group health plan or Medicare and you must not have any other health insurance coverage.]

☐ **[Yes, I meet the above criteria and am applying for Guarantee Issue coverage**.]

[NOTE: If not all individuals applying for coverage meet the HIPAA requirements, those who are not HIPAA eligible must complete a separate Application for Health Coverage which will be reviewed through the regular underwriting process.]

Medical Information

The Medical Details section requires your careful attention to each question. The questions below should be answered by you and not by any broker representing you. If you fail to provide truthful or accurate health history information you may lose your coverage or other penalties may apply. You may want to consult your physicians if you have questions regarding the information requested below.

Answer questions on behalf of all individuals applying for coverage. Each individual applying for coverage needs to provide his or her own medical history. Only provide a family member's medical history if the family member is also applying for coverage on this Application. A person applying for coverage does not need to provide any genetic information (including genetic testing, genetic counseling, or genetic education).

Check "Yes" or "No," and provide additional information in the Medical Details section when necessary.	
1 Physical Exam	
Has any individual applying for coverage had a physical or wellness exam within the past [6 months - 2 years]? If "Yes," provide details in the Medical Details section.	☐ **Yes** ☐ **No**
2 Pregnancy	
Is any individual applying for coverage currently pregnant, expecting a child with anyone, an expectant or surrogate parent, or in the process of adopting a child?	☐ **Yes** ☐ **No**
3 [Female Health History	
3a. **Has any female applying for coverage had a Pap smear/pelvic exam within the last 2 years?** If "Yes," provide results of exam: ☐ Normal ☐ Abnormal (If abnormal, complete the Medical Details section) 3b. **Has any female applying for coverage had a mammogram within the last 2 years?** If "Yes," provide results or exam: ☐ Normal ☐ Abnormal (If abnormal, complete the Medical Details section)]	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4 Transplants	
Has any individual applying for coverage been a candidate or recipient of an organ or bone marrow transplant? If "Yes," provide details in the Medical Details section.	☐ **Yes** ☐ **No**
5 HIV / ARC / AIDS	
In the past ten (10) years has any individual applying for coverage been diagnosed, received a positive test, or received treatment for Human Immunodeficiency Virus (HIV) or AIDS Related Complex / Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency?	☐ **Yes** ☐ **No**

[Applicant Name: _____**]** **[Agent Name:** _____**]**

Check all that apply. In the past [2 - 10] years, has any individual applying for coverage been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any of the following? If nothing in a category applies, select the "None" box. Provide details for all checked items (including "Other") in the Medical Details section.

6 Cancer / Cyst / Tumor		
☐ Carcinoma, sarcoma, leukemia, lymphoma, myeloma, central nervous system cancers or carcinoma in situ	☐ Cyst, growth, lump, mass, tumor or polyp ☐ Other	☐ None
7 Respiratory System		
☐ Allergies or asthma ☐ Emphysema or chronic lung disease (COPD)	☐ Sleep apnea ☐ Other	☐ None
8 Cardiovascular and Circulatory System		
☐ Hypertension or high blood pressure ☐ Deep Venous Thrombosis or phlebitis ☐ Varicose veins, blood clot or aneurysm	☐ Irregular heartbeat, heart murmur, or mitral valve prolapse ☐ Heart attack, chest pain or angina ☐ Other	☐ None
9 Digestive System		
☐ Chronic abdominal pain, ulcer, acid reflux or hiatal hernia ☐ Diverticulitis, diverticulosis, hemorrhoids, or hernia ☐ Disorder of the esophagus, stomach, colon, rectum, intestine, bowel, gallbladder or pancreas	☐ Liver condition or hepatitis A ☐ Cirrhosis, fatty liver or hepatitis B or C ☐ Surgical treatment for obesity, gastric bypass or banding ☐ Other	☐ None
10 Emotional or Mental Health		
☐ Anxiety or depression ☐ Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder ☐ Bipolar disorder	☐ Obsessive Compulsive Disorder, schizophrenia ☐ Eating disorder ☐ Therapy or counseling ☐ Other	☐ None
11 Muscular or Skeletal System		
☐ Bursitis, tendonitis or gout ☐ Disorder of the back, neck or spine ☐ Connective tissue disorder, systemic lupus, rheumatoid arthritis ☐ Fibromyalgia ☐ Disorder of the knee, shoulder, hip or other joint ☐ Osteoarthritis, osteoporosis or osteopenia	☐ Temporomandibular joint disorder (TMJ) ☐ Fractures or broken bones ☐ Prosthetic limbs or devices, or internal fixations(pins, plates, screws) ☐ Any chiropractic treatments ☐ Other	☐ None
12 Skin		
☐ Acne or rosacea ☐ Eczema or psoriasis	☐ Abnormal or cancerous moles, melanoma ☐ Other	☐ None
13 Eyes / Ears / Nose / Throat		
☐ Disease or injury of eye ☐ Cataracts or glaucoma ☐ Ear disorder, ear infections or tubes in ears ☐ Hearing loss or cochlear implant	☐ Deviated septum or sinus infection ☐ Disorder of the throat, tonsils or adenoids ☐ Other	☐ None
14 Kidney or Urinary Tract		
☐ Bladder or urinary tract infection or disorder ☐ Kidney infection or disorder	☐ Kidney or bladder stones ☐ Other	☐ None
15 Female Reproductive System		
☐ Disorder of the breast or abnormal mammogram ☐ Saline breast implants ☐ Silicone breast implants ☐ Abnormal Pap smear ☐ Endometriosis, uterine fibroids or uterine prolapse	☐ Infertility or complications of pregnancy ☐ Menopausal disorder ☐ Menstrual disorder ☐ Cervical, ovarian, uterine or vaginal disorder ☐ Other	☐ None
16 Male Reproductive System		
☐ Infertility ☐ Penile or testicular disorder	☐ Prostate disorder, elevated PSA, Prostatitis ☐ Other	☐ None

[Applicant Name: _____**]** **[Agent Name:** _____**]**

17 Sexually Transmitted Diseases		
☐ Chlamydia ☐ Genital warts ☐ Genital herpes	☐ Human Papilloma Virus (HPV) ☐ Gonorrhea or syphilis ☐ Other	☐ None
18 Blood / Adrenal / Endocrine / Pituitary / Thyroid		
☐ Anemia ☐ Diabetes ☐ Elevated blood sugar ☐ Elevated cholesterol or triglycerides	☐ Endocrine, adrenal, or pituitary disorder ☐ Weight disorder ☐ Thyroid disorder ☐ Other	☐ None
19 Brain or Nervous System		
☐ Concussion or head injury ☐ Migraines or chronic headaches ☐ Convulsions, seizures, epilepsy, fainting, tics or tremors	☐ Stroke, Transient Ischemic Attack (TIA) or paralysis ☐ Multiple sclerosis ☐ Other	☐ None
20 Congenital or Development		
☐ Cleft palate or cleft lip ☐ Developmental disorder or delay	☐ Mental retardation, autism, or Down's Syndrome ☐ Other	☐ None
21 Alcohol / Drug		
☐ Alcohol abuse, dependency or alcoholism ☐ Drug / substance abuse or dependency	☐ A citation or conviction for driving under the influence of alcohol or any drug / substance ☐ Other	☐ None

22 Other Conditions	
In the past [2 - 10] years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any other condition(s) not listed on this Application? If "Yes," provide details in the Medical Details section.	☐ Yes ☐ No

Medical Details

Please provide COMPLETE details for all questions with a "Yes" answer or a checked box in the Medical Information section. Provide the question number you are referencing in the first column. If you need more space, **attach a separate sheet of paper** with the details in the same format as the box below. Sign and date any attachments.

Q#	Name of Individual Applying for Coverage (Last, First, MI)	Explain Nature of Illness / Condition (include results of any physical exam)	Date of Onset (mm/yy)	Date of Recovery (mm/yy)	Remaining or Ongoing Symptoms or Treatment
	Treating Physician's Name	Address		Phone Number	
	Treating Physician's Name	Address		Phone Number	
	Treating Physician's Name	Address		Phone Number	
	Treating Physician's Name	Address		Phone Number	

[Applicant Name: _____] [Agent Name: _____]

	Treating Physician's Name	Address		Phone Number	
	Treating Physician's Name	Address		Phone Number	

Medications

Please provide COMPLETE details for all medications (prescription or over-the-counter) currently being taken or that have been taken by (including samples), or were prescribed or recommended for, any individual applying for coverage in the past [12] [24] months. If you need more space**, attach a separate sheet of paper** with the details in the same format as the box below. Sign and date any attachments.

Name of Individual Applying for Coverage (Last, First, MI)	Date Started (mm/yy)	Date Discontinued (mm/yy)	Medication Name	Dosage and Frequency	Condition / Reason for taking

Acknowledgements

By signing this Application form, I, the Applicant, including any undersigned Spouse and Dependents, agree to the following statements:

- I understand that all individuals applying for health coverage listed on this Application are subject to medical underwriting review [unless applying for Guarantee Issue coverage]. I understand that the selling agent (if applicable) has no authority to promise coverage to the applicant or any individual applying for coverage, or to modify Coventry's underwriting criteria or terms of coverage.
- I understand that the information that I provide on this Application will be used to determine whether Coventry Health and Life Insurance Company accepts my Application and so provides me with a policy of health coverage for which I'm applying [including Guarantee Issue coverage]. I attest that my Application responses are complete and accurate to the best of my knowledge.
- I understand that if any information is omitted or misrepresented, it could provide the basis to refuse, terminate, reform or rescind coverage and to adjust as applicable, or refund any premiums paid as though coverage had never been in force. In the event that coverage is rescinded, the policy will be voided back to the original effective date and [all premium payments will be refunded]. Coventry shall not be financially liable for any health care services rendered prior to the rescission.
- I agree to notify Coventry Health and Life Insurance Company in writing if I or any individual applying for health coverage receives any new diagnosis, treatment, or health service, or if any of the answers or statements provided on this Application change between the date this Application is signed and the effective date or approval date of coverage, whichever is later. My failure to provide Coventry Health and Life Insurance Company with this updated health information may result in a denial or rescission of coverage.
- I understand that if any individual applying for coverage is declined for coverage, that individual may not re-apply for Coventry*One* coverage for six (6) months from date of signature.
- I understand that this Application is valid for sixty (60) days from the earliest date of signature in the Acknowledgements section.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

[Applicant Name: _____] **[Agent Name: _____]**

[Coventry*One*] Underwritten by Coventry Health and Life Insurance Company
DO NOT cancel your existing insurance coverage until an offer of coverage has been extended by Coventry in writing. Please retain a copy of this application for your records.]

Primary Applicant's Signature	**Date**	**Spouse's Signature** (if applying for coverage)	**Date**
Dependent Signature[1]	**Date**	**Dependent Signature**[1]	**Date**

[1]Dependent Signature is required for individuals applying for coverage ages 18 and over

[FOR AGENT USE ONLY]

[**Agent Certification**: I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this Application or any supplement to it. I have not advised any individual applying for coverage to withhold any information regarding the answers to the questions and have advised the individuals applying for coverage to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that all my answers recorded in this application are correct, complete, and wholly true to the best of my knowledge and belief.]

[Agent name]	[Agent ID#]	[Agent E-mail]
[Agency name]	[Agent / Agency phone]	[Name of General Agent]
[Payee (who is paid commissions)] ☐ Agent ☐ Agency ☐ General Agent	[Payee Tax ID#]	
[Agent Signature	**Date]**	

[Coventry*One*] Underwritten by Coventry Health and Life Insurance Company

Premium Payment

Premium Payment Options [Choose **ONE** payment option.] [You must then complete the applicable sections regarding your account information.]

[Initial payment by EFT, then:]	[Initial payment by credit card, then:]	[Initial payment by check, then:]
☐ [Monthly EFT (no administrative fee)]	☐ [Monthly EFT (subject to [one time Administrative Fee of [$1-$10] per person)]	☐ [Monthly EFT (subject to one time Administrative Fee of $5 per person)]
☐ [Monthly credit card draw (subject to Administrative Fee of [$1-$10] per person per month)]	☐ [Monthly credit card draw (subject to Administrative Fee of [$1-$10] per person per month)]	☐ [Monthly credit card draw (subject to Administrative Fee of [$1-$10] per person per month)]
☐ [Monthly billing (subject to Administrative Fee of [$1-$10] per person per month)]	☐ [Monthly billing [(subject to Administrative Fee of [$1-$10] per person per month)]	☐ [Monthly billing (subject to Administrative Fee of [$1-$10] per person per month)]

[Payroll Deduction Program This program allows your premium to be deducted directly from your paycheck, post-taxes. Other details apply. To choose this option, you **MUST** submit a separate Coventry*One* Payroll Deduction Authorization Form with your Application.]

☐ **[NEW Payroll Deduction Program (PDP)]**	☐ **[EXISTING Payroll Deduction Program (PDP)** PDP number: _____ PDP name: _____]

[EFT (Electronic Funds Transfer) Information] [Complete this section if you have chosen to pay by EFT. When choosing EFT, your monthly premium will be withdrawn automatically from the bank account listed on the [10th] day (or the next business day if a weekend/holiday) of the month for which premium is due. If the effective date is anything other than the 1st of the month, the initial premium will be prorated based on your effective date.]

☐ Checking Account ☐ Savings Account	Name of account holder	9-digit routing number	Account number
Name of bank / savings institution		Relationship of account holder to Primary Applicant ☐ Self ☐ Spouse ☐ Other_____	
Account holder address		City	State / ZIP

[Credit Card Information] [Complete this section if you have chosen to pay by credit card. If the effective date is anything other than the 1st of the month, the initial premium will be prorated based on your effective date.]

☐ [VISA] ☐ [MasterCard]	[Name of card holder (exactly as on card)]	[Card number]	[Exp. date (mm/yyyy)]	[Verification code[1]]
[Card billing address]		[City]	[State]	[ZIP]

[Monthly Billing Information] [If you choose Monthly Billing, your bill will be sent to the Mailing Address you supplied in the] [Primary Applicant Information] [section on page] [1]. [At this time, we are unable to bill you at an alternate address.]

[1 The Verification Code for your Visa or MasterCard is a 3-digit code printed near the signature strip on the back of your card.]

[**Important Note:** Coventry*One* is not an employer-sponsored group health plan. If your banking information is from a business account, or you are submitting a check drawn from a business account, you must contact us to complete a CoventryOne Payroll Deduction Authorization Form.]

By signing this Premium Payment section, you are agreeing to the following statements:

- You understand that it is your responsibility to notify Coventry Health and Life Insurance Company at [phone number] should your payment information change at any time while you continue to hold a [Coventry*One*] policy.
- You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of [$20.00]. You authorize <Plan> to collect the premium payment due between the [5th-15th] of the month, including any unpaid fee amount. Failure to remit the first payment could result in rescission.
- You understand that providing this payment information does not guarantee approval or coverage.
- Upon approval and acceptance of this Application, you authorize Coventry Health and Life Insurance Company to initiate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. [Depending on your effective date, your first automatic withdrawal may include up to, but not in excess of, two times your monthly premium amount.]

Account / Card Holder Signature:_____ **Date:**_____

[Applicant Name: _____**]** **[Agent Name:** _____**]**

Authorization of Release of Information

I, the Applicant, for myself and any of my Dependents who are under the age of 18 and who are applying for coverage hereunder, hereby make the following authorizations:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to Coventry Health and Life Insurance Company or its authorized representatives, my (or my Dependents') personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I also authorize the release of information relating to mental illness.

[The information authorized for release may include the presence of a communicable or non-communicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).]

In addition, I authorize Coventry Health and Life Insurance Company to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by Coventry Health and Life Insurance Company for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for Coventry Health and Life Insurance Company to consider my Application and to determine whether or not an offer of coverage will be made. No action will be taken on my Application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by Coventry Health and Life Insurance Company as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request.

I authorize Coventry Health and Life Insurance Company to use or disclose the information I provide in this Application (or that the Coventry Health and Life Insurance Company has or receives from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) but shall not exceed twenty-four (24) months from the date signed. Any revocation will not affect the activities of Coventry Health and Life Insurance Company prior to the date such revocation is received by Coventry Health and Life Insurance Company.

[ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.]

Primary Applicant's Signature	**Date**	**Spouse's Signature** (If applying for coverage)	**Date**
Dependent Signature*	**Date**	**Dependent Signature***	**Date**

*Required age 18 and over.

[Applicant Name: _____] **[Agent Name: _____]**

CoventryOne.

The CoventryOne Family of Brands
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Underwritten by Coventry Health & Life Insurance Company

[Health Plan Name] [Special State or Association Name]

Change Request Form

Important: Please print clearly in BLACK ink. Refer to your contract for eligibility requirements. Please keep a copy of this form for your records.

Submit your completed Change Request Form to:

E-mail: planchanges@cvty.com
FAX: 877-815-8747
Address: ATTN: Plan Changes
CoventryOne Individual Underwriting
P.O. Box 61440, TecPort Drive
Harrisburg, PA 17106-1440

Check all that apply (up to three (3) changes are permitted per form):

☐ Contact Information / Name Change ☐ Newborn Addition ☐ Remove / Move Dependents ☐ Decrease Benefits / Cancel Coverage ☐ Other

Primary Member Information This section is **required** for all requested changes and must reflect the information on your ID card.

Last name	First name	MI	Member ID number	Primary phone ( ) -

Address / Name Change Complete this section for changes in name, phone number, E-Mail, home address or mailing address.

Member name change (indicate both previous and new name)	New phone number	New E-mail address

New home address (Street, City, State, ZIP)	New mailing address (Street, City, State, ZIP)

Newborn Addition Complete this section to add a newborn or newly adopted child to your coverage. Requests must be received within 31 days (60 days in Iowa) of the date of birth or a new Application must be submitted and will be subject to medical underwriting.

Last name	First name	MI	Gender M F	Birthdate (mm/dd/yyyy)	Social Security Number

Remove / Move Dependents Complete this section for changes to current dependents.

Full name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)	Change requested (select ONE only)	Requested Effective Date of Change (mm/dd/yyyy)
			☐ Move to own policy ☐ Move to a new policy with other dependents ☐ Remove from policy; discontinue coverage	
			☐ Move to own policy ☐ Move to a new policy with other dependents ☐ Remove from policy; discontinue coverage	
			☐ Move to own policy ☐ Move to a new policy with other dependents ☐ Remove from policy; discontinue coverage	

Decrease Benefits or Cancel Coverage A request for a reduction in benefits or cancellation of coverage must be submitted by the end of the month prior to the requested effective date of change. Retroactive benefit reductions and terminations are not permitted. Benefit plan changes affect all covered members. Decreasing your benefits does not change your renewal date, at which time your rates will be recalculated.

☐ **Decrease my benefits.** Requested Effective Date _____ Change plan to: _____	☐ **Cancel my coverage.** Requested date of cancellation _____ Reason for cancellation: _____

Other Explain other requested changes in the space below. Note that certain changes require submission of a new Application for Health Coverage. These changes include addition of a spouse, an increase in benefit level and addition of a new dependent after 31 days of birth or adoption. Changes to banking information should be submitted on a new Banking Information Form.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

Primary Applicant's Signature	**Date**	**Spouse's Signature**	**Date**
Dependent Applicant Signature**	**Date**	**Dependent Applicant Signature****	**Date**

**Required age 18 and over.

Outline of Coverage
for Individual Health Benefit Policies

Arkansas

Coventry*One*® is underwritten by Coventry Health and Life Insurance Company
and administered by [Coventry Health Care of Kansas, Inc].

IMPORTANT NOTICE

This summary is a partial description of the Coventry*One* Policy underwritten by Coventry Health and Life Insurance Company, and in no way details all of the benefits, limitations, or exclusions of the plan. Please refer to the Individual Policy, Schedule of Benefits and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

[INSERT FORM CHL-AR-SOB-003-10.10]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by Coventry Life and Health Insurance Company. Your new policy provides ten (10) days within which you may decide without cost whether you desire to keep the policy. For our own information and protection you should be aware of any seriously consider factors which may affect the insurance protection available to you under the new policy.

- Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write Coventry Health & Life Insurance Company, [Coventry*One* Medical Underwriting, PO Box 7109, London, KY 40742], or call us at [(800) 969-3343], within ten (10) days if any information is not correct and complete, or if any past medical history has been left out of the application.

Read Your Policy Carefully

This outline of coverage provides a very brief description of important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY**.

Major Medical Expense Coverage

Policies of this category are designed to provide to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy.

Termination of Policy and Renewal

This Policy shall be renewable at the option of the Insured, except as described immediately below. Non-renewal shall not be based upon the deterioration of mental or physical health of the Insured under this Policy. Your Coverage shall terminate if any one of the following events occurs:

- **Cancellation.** You may cancel this Policy at any time by written notice delivered or mailed to the Plan, effective upon receipt of such notice or on such late date as may be specified in such notice. In the event of cancellation or death of the Insured, the Plan will promptly return the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
- **Loss of Eligibility.** If You no longer meet the eligibility requirements set forth in the Policy, Your coverage shall end at 11:59 p.m. on the date You no longer meet the eligibility requirements.
- **Rescission of Coverage.** Coverage for an Insured under the Policy may be canceled, Reformed or Rescinded based on medical or other enrollment or eligibility information received which was not properly or completely disclosed, or was falsely disclosed in Your Application agreement, prior to contracting or enrollment. NOTE: If an Insured's coverage is Rescinded, coverage will be termed back to the effective date and the Plan will seek recovery of all payments made on the Your behalf. Therefore, both the Plan and the Insured will be returned to a financial position as if no coverage had ever been in force. The Plan may initiate this action in the event that, among other possible reasons, there is a Material Misrepresentation that led the Plan to provide coverage. However, an Insured's coverage will not be Rescinded due to improper disclosure on the Application agreement after coverage has been in effect for two years. This exception does not apply in the case of fraudulent misrepresentation.
- **Non-payment of Premiums.** You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the ten (10) day grace period, you will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the ten (10) day grace period.
- **Fraud.** You participate in fraudulent or criminal behavior, including but not limited to:
    - Performing an act or practice that constitutes fraud or Material Misrepresentation of facts including, but not limited to using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled.
    - Allowing any other person to use Your identification card to obtain services. If the Insured allows any other person to use his/her identification card to obtain services, the Coverage of the Insured will be terminated.

- Knowingly misrepresenting, omitting or giving false information on any Policy forms and medical questionnaire.

Exclusions and Limitations

Pre-Existing Conditions Limitation

Pre-Existing Conditions may affect your premium rate, may result in denial of your application, or we may deny Coverage for them for a period of time after your effective date. If you are accepted for Coverage, your premium rate will be calculated to include any Pre-Existing Condition that you disclosed on your enrollment form, and such conditions will be Covered under the terms of your Policy beginning on your effective date. Any Pre-Existing Condition(s) that is not disclosed on your enrollment form will be excluded from Coverage for a period not longer than twelve (12) months after your effective date.

Note: Effective September 23, 2010 The Pre-Existing Conditions limitation does not apply to persons age eighteen (18) or younger.

Non-Duplication of Coverage Under Certain Laws

This Policy will always be secondary to any state no-fault law that requires motor vehicle liability policies to provide personal injury protection insurance for the insured and any passengers. Individual automobile "no fault" medical payment contracts that provide personal injury protection or no-fault benefits in excess of the minimum limits required by state law will remain primary to the limit or extent of the personal injury protection benefit provided in the automobile insurance policy. The plan benefits will be reduced by the amount of the personal injury protection coverage paid for by any such no-fault law or limit provided in the applicable automobile insurance policy. If a vehicle insurance policy has a provision providing personal injury protection coverage, whether required by law or not, such coverage will be primary over coverage provided by this Policy. The Insured agrees to furnish information to the Plan concerning any applicable personal injury protection insurance upon request.

Right of Recovery

The Plan has the right to correct benefit payments that are made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payments if any underpayments have been made

General Exclusions

Unless otherwise stated in this Policy, the following items are excluded from Coverage:

1) Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Policy;
2) Any service or supply that is not Medically Necessary;
3) Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service;
4) Any service or supply for which You have no financial liability or that was provided at no charge; those services for which the Insured has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Policy;
5) Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;
6) Court-ordered services or services that are a condition of probation or parole;
7) Those services otherwise Covered under the Policy, but rendered after the date Coverage under the Policy terminates, including services for medical conditions arising prior to the date individual Coverage under the Policy terminates; and
8) Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as the Insured, or rendered by a person who is a member of the Insured's family, including Spouse, brother, sister, parent, step-parent, child or step-child.

Specifically excluded services include, but are not limited to, the following:

1) Acupuncture - Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not Covered;
2) Allergy Services - Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;
3) Alternative Therapies - Alternative therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;
4) Ambulance Service - Non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Insured;
5) Augmentative Communication Devices – Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Insureds;

6) Autopsy - Those services and associated expenses related to the performance of autopsies, and also post-mortem genetic studies;
7) Behavior modification;
8) Biofeedback;
9) Blood and Blood Products - The cost of whole blood and blood products replacement to a blood bank;
10) Blood Storage - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;
11) Braces and supports needed for athletic participation or employment;
12) Charges resulting from Your failure to appropriately cancel a scheduled appointment;
13) Cochlear Implants and related services;
14) Cosmetic Services and Surgery - Those services, associated expenses, or complications resulting from Cosmetic Surgery, which alters appearance but does not restore or improve impaired physical function. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes;
15) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;
16) Custodial Care, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists the Insured in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services;
17) Dental Services - Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the surgical treatment of temporomandibular joint disorder ("TMJ"), whether the services are considered to be medical or dental in nature except as provided in the "Covered Services" Section of this Policy. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). The diagnosis and treatment for TMJ and craniomandibular joint disease is not Covered unless by an attached Rider. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;

    Also excluded from coverage are dental services when such services are directly related to an accidental injury. This includes but is not limited to treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an accidental injury.
    Removal of teeth, including any prophylactic extractions, as a complication of radionecrosis is not a Covered Service
18) Dental Surgery and Implants - Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded.;
19) Medical services and expenses incurred for learning disabilities, developmental delays, mental retardation, and autistic disorders.
20) Durable Medical Equipment ("DME") - Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home blood pressure monitoring devices; home oximetry units; home traction units; replacement for changes due to obesity; preventive or routine maintenance due to normal wear and tear or negligence of items owned by the Insured; personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services;
21) Educational Services Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;
22) Equipment or services for use in altering air quality or temperature;
23) Educational testing or psychological testing, unless part of a treatment program for Covered Services;
24) Elective or Voluntary Enhancement - Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan;
25) Eligible Expenses - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;
26) Enteral Feeding Food Supplement - The cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

27) Examinations - Unless otherwise Covered under the Covered Services Section, those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, travel, employment, insurance, marriage or adoption. Also excluded are services relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type;
28) Exercise equipment, hot tubs and pools;
29) Eye Glasses and Contact Lenses - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;
30) Food or food supplements , regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease;
31) Foot Care – Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Insured;
32) Foreign Travel - care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services;
33) Growth Hormone – Growth hormone therapy for any condition, except in children less than 18 years of age who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan;
34) Hair analysis, wigs and hair transplants - Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Provider;
35) Home services to help meet personal, family, or domestic needs;
36) Health and Athletic Club Membership - Any costs of enrollment in a health, athletic or similar club;
37) Hearing Services and Supplies - Those services and associated expenses for hearing aids, cochlear implants, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests, unless Covered by an attached Hearing Aid Rider;
38) Household Equipment and Fixtures - Purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;
39) Hypnotherapy and Hypnosis;
40) Immunizations unless specifically covered under the Policy, including but not limited to immunizations required for travel, school, work-related, Anthrax vaccine and Lyme Disease vaccine. Also excluded are examinations and testing in connection with insurance, obtaining employment, specifically for the purpose of entering school, participating in extracurricular school activities, adoption, immigration and naturalization, or examinations or treatment ordered by a court or an employer; premarital blood testing;
41) Infertility/Reproductive Services - All diagnostic studies, non-diagnostic services, and certain surgical procedures that are related to diagnosing and/or treating Infertility. Also excluded are expenses incurred for the promotion of conception including, but not limited to, artificial insemination, intracytoplasmic sperm injection ("ICSI"), in vitro or in vivo fertilization, gamete intrafallopian transfer ("GIFT") procedures, zygote intrafallopian transfer ("ZIFT") procedures, embryo transport, egg harvesting (collection, storage, preparation), reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis (for example, determining sex) , other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered under the terms of the Policy; No legal obligation to pay - Services are excluded for Injuries and Illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health services and supplies furnished under or as part of a study, grant, or research program;
42) Maternity Services – Expenses incurred for any condition of or related to pregnancy, except complications arising from and unless specifically covered in the Schedule of Benefits. Also excluded are expenses associated with selective reduction during pregnancy.
43) Maintenance Therapy – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;
44) Male Gynecomastia – Those services and associated expenses for treatment of male gynecomastia.

45) Massage Therapy – Those services and associated expenses related to massage therapy;

46) Medical complications arising directly or indirectly from a non-Covered Service;

47) Mental Health Services - the diagnosis and treatment of all biologically based Mental Illnesses and psychiatric conditions, unless Covered by an attached Mental Health Substance Abuse Rider;

48) Military Health Services - Those services for treatment of military service-related disabilities when the Insured is legally entitled to other Coverage and for which facilities are reasonably available to the Insured; or those services for any Insured who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;

49) Miscellaneous Service Charges - Telephone consultations, document processing or copying fees, mailing costs, charges for completion of forms, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), any late payment charge, interest charges or other non-medical charges;

50) Non-Prescription Drugs and Medications - Over-the-counter ("OTC") drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

51) Nutritional-based Therapy - Nutritional-based therapies except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

52) Newborn home delivery and also the cost of child birth classes;

53) Obesity Services - Those services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature

54) Occupational Injury - Those services and associated expenses related to the treatment of an occupational Injury or Illness for which the Insured is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services under this Policy;

55) Oral Surgery Supplies - required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;

56) Orthodontia and related services;

57) Orthotic Appliances, Repairs or Replacement - The replacement costs for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated; also excluded are cranial (head) remodeling band for the treatment of postitional non-synostotic plagiocephaly; and other protective head gear;

56) Over-the-counter supplies such as ACE wraps, elastic supports, finger splints, Orthotics, and braces; also OTC products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

59) Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

60) Prescription Drugs and Medications - Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider.

61) Private Duty Nursing - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;

62) Prosthetic Devices Repairs or Replacement - The replacement costs for any otherwise Covered device, including replacement for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured;

62) Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable;

64) Reduction or Augmentation Mammoplasty - Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer;

65) Reversal of Sterilization Services - Those services and associated expenses related to reversal of voluntary sterilization;
66) Sex Transformation Services - Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;
67) Sexual Dysfunction - Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;

68) Sleep Studies – Sleep studies provided within the home;

69) Smoking Cessation - Those services and supplies for smoking cessation programs and treatment of nicotine addiction;

70) Speech therapy or voice training when prescribed for stuttering or hoarseness;
71) Sports Related Services - Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces and orthotics;

72) Substance Abuse diagnosis and treatment, unless Covered by an attached Mental Illness Substance Abuse Rider;
73) Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of the Insured acting as a surrogate mother;

75) Transplant Organ Removal - Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not Covered under the Policy unless the recipient is the Insured and the donor's medical Coverage excludes reimbursement for organ harvesting;
76) Transplant services, screening tests, and any related conditions or complications related to organ donation when the Insured is donating organ or tissue to a person not Covered under the Policy;

77) Transplant Services and associated expenses involving temporary or permanent mechanical or animal organs;

78) Travel Expenses - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section;

79) Treatment for disorders relating to learning, motor skills and communication;

80) Vision Aids, Associated Services - Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;
81) Vocational therapy;

82) Health services resulting from war or an act of war when the Insured is outside of the continental United States; and

83) Work hardening programs.

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 01/13/2011	2011 01 01		New		2011 01 01 (Rev 2).pdf

ACTUARIAL MEMORANDUM
COVENTRY HEALTH AND LIFE INSURANCE COMPANY
ARKANSAS SERVICE AREAS
Individual PPO Filing

1. Scope and Purpose:

I, James W. Brown, am a Member of the American Academy of Actuaries and an Associate of the Society of Actuaries. Coventry Health and Life Insurance Company (CHL) is filing rates for prospective business within its Arkansas service areas sold to individuals. The rates in this filing are for new individual plans, and the description of coverage is enclosed. It is not appropriate to use this actuarial rate certification for any other purpose.

2. Proprietary:

CHL considers this submission to contain proprietary information. We respectfully request that it be kept confidential to the maximum extent permitted under law.

3. Description of Benefits:

CHL will offer PPO benefit plans to individuals. This offering utilizes a variety of copay, coinsurance, deductible, and out-of-pocket options. Benefit options for the new plans are described in the New Plan Summary enclosed in Attachment 1.

4. Renewability:

The individual policy is guaranteed renewable at the option of the policyholder, except for reasons as described in the policy. Premiums listed are on a monthly basis.

5. Applicability:

The rating factors are appropriate for contracts with January 1, 2011 - March 30, 2011 effective dates. The rates included apply to new business and renewal business.

6. Morbidity:

Medical cost assumptions used to develop the rates are based on analysis of Mercy Health Plan (recently acquired by Coventry Health Care) experience, provider network performance experience, assumed utilization patterns and anticipated changes in utilization trends for the projection period.

6705 Rockledge Drive • Suite 900 • Bethesda, MD 20817-1850
301.581.0600 • 800.843.7421

7. **Mortality:**

   Mortality was not used in developing the rates.

8. **Persistency:**

   Persistency is anticipated to be 70% in all policy years.

9. **Expenses:**

   Expenses are priced for using the PPACA minimum loss ratio threshold of 80%. As the minimum loss ratio threshold is a one-sided test, the American Academy of Actuaries (AAA) prepared a credibility adjustment intended to provide for statistical fluctuations in results. Based on our anticipated enrollment of 2,000 lives, the adjustment provided in the AAA study is 12%. As such, this filing assumes a target loss ratio of 68%. Expenses will be managed internally around this level, including broker commissions.

10. **Marketing Method:**

    CHL products are sold to individuals through CHL representatives and independent, licensed brokers and agents.

11. **Underwriting:**

    Medical underwriting guidelines are applied consistently and fairly on all applicants.

12. **Premium Classes:**

    CHL will offer one class of business.

13. **Issue Age Ranges:**

    CHL will issue and renew until Medicare eligible due to age, except where limited by law.

14. **Premium Modalization Rules:**

    Not applicable.

15. **Active Life Reserves:**

    Active life reserves will be held under the guidance set forth in Arkansas law and regulation, NAIC guidelines, and Actuarial Standards of Practice.

16. **Trend Assumptions:**

    The maximum trend rate that will be applied is: 10%. Lower trend rates may apply based on emerging experience and expected future claims levels. This trend will only be applied upon renewal.

17. **Rating Methodology**

    CHL will utilize age and gender specific rates.

18. **Anticipated Loss Ratios:**

    The anticipated loss ratio for this block of business is 68.0%, as described in the expense section.

19. **Past Experience and Lifetime Loss Ratio:**

    Since this is a new product and rate filing, there is no prior experience.

20. **History of Rate Adjustments:**

    Since this is a new product and rate filing, there are no prior rate adjustments.

21. **Numbers of Policyholders:**

    Since this is a new product and rate filing, there are no prior current members in the Arkansas service areas.

22. **Proposed Effective Date:**

    The new rating factors are appropriate for contracts with January 1, 2011 effective dates.

23. **Rates:**

    Please see attached rate pages (Attachment 2). Premium rates for individuals will vary by benefit plan design, underwriting, age/gender, and area. The development of projected base rates for 2011 was based on the experience of the recently acquired Mercy Health Plans experience in Arkansas, as shown in Attachment 3. We consider Attachment 3 proprietary. We respectfully request that it be kept confidential to the maximum extent permitted under law.

COVENTRY
Health and Life Insurance Company

24. Actuarial Certification:

I, James W. Brown, have reviewed the premium and claim experience used to develop the proposed rates for the individual products in Arkansas. I have relied on analysis provided by staff of Mercy Health Plan, and have reviewed the information for reasonableness.

I hereby certify that to the best of my knowledge and ability, the following are true with respect to this filing:

a. The assumptions present the actuary's best judgment as to the expected value for each assumption
and are consistent with the issuer's business plan at the time of the filing.

b. The filing is in compliance with applicable laws and regulations in the state.

c. The loss ratios comply with the regulatory loss ratio requirements.

d. The rates are adequate and reasonable in relationship to the benefits provided, and are not excessive or unfairly discriminatory between policyholders.

e. The rates comply with accepted actuarial practices.

October 28, 2010
Date

James W. Brown, ASA, MAAA
Director
Coventry Health Care, Inc.
1100 Circle 75 Parkway
Atlanta, GA 30339
Phone: (678) 202-2145
E-Mail: jwbrown@cvty.com

Coventry Health and Life Insurance Company
Arkansas Individual - New Plans 2011
Attachment 1

	PLAN A		PLAN B		PLAN C		PLAN D		PLAN E		PLAN F		PLAN G	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Deductible	$1,000	$2,000	$2,500	$5,000	$5,000	$10,000	$1,000	$2,000	$1,500	$3,000	$2,500	$5,000	$5,000	$10,000
Coinsurance	80%	60%	80%	60%	80%	60%	80%	60%	80%	60%	80%	60%	80%	60%
Out of Pocket	$3,500	$7,000	$5,000	$10,000	$7,500	$15,000	$4,500	$9,000	$5,000	$10,000	$6,000	$12,000	$8,500	$17,000
Hospital	100%	75%	100%	75%	100%	75%	80%	60%	80%	60%	80%	60%	80%	60%
PCP Office Visit	$30	75%	$30	75%	$30	75%	$30	60%	$30	60%	$30	60%	$30	60%
Specialist	$60	75%	$60	75%	$60	75%	$60	60%	$60	60%	$60	60%	$60	60%
ER	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200
Urgent Care	$75	$200	$75	$200	$75	$200	$75	$200	$75	$200	$75	$200	$75	$200
Preventive Health	100%	75%	100%	75%	100%	75%	100%	75%	100%	75%	100%	75%	100%	75%
Ambulance	100%	100%	100%	100%	100%	100%	80%	80%	80%	80%	80%	80%	80%	80%
Chiropractor	Visit Limits		Visit Limits		Visit Limits		Visit Limits		Visit Limits		Visit Limits		Visit Limits	
Vision	$60		$60		$60		$60		$60		$60		$60	
Mental Health/Substance Abuse	Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above	
Hearing Aids/Service	Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above	
TMJ	Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above	
RX Tier 1	$10	50%	$10	50%	$10	50%	$10	50%	$10	50%	$10	50%	$10	50%
RX Tier 2	$35	50%	$35	50%	$35	50%	$35	50%	$35	50%	$35	50%	$35	50%
RX Tier 3	$70	50%	$70	50%	$70	50%	$70	50%	$70	50%	$70	50%	$70	50%
RX Tier 4	75%	50%	75%	50%	75%	50%	75%	50%	75%	50%	75%	50%	75%	50%

* Maternity is not covered under these plans
** All essential benefits are unlimited from a dollar perspective, as required under PPACA

Coventry Health and Life Insurance Company
Arkansas Individual Plans
Age and Area Factors
January 1, 2011

Exhibit 2

Age Factors

Age Band	Male	Female
6 months - 1 yr	1.244	1.244
1-4	1.244	1.244
5-18	0.602	0.602
19-24	0.564	0.770
25-29	0.640	0.923
30-34	0.813	1.175
35-39	1.000	1.395
40-44	1.277	1.547
45-49	1.627	1.810
50-54	2.187	2.181
55-59	2.847	2.593
60-64	3.757	3.096
65+	3.757	3.096

Smoker Load:	20%
TMJ Rider Rate:	$2.20
MH/SA Rider Rate:	$8.65
Hearing Aid Rider Rate:	$1.90
Maximum Annual Trend:	10%

Area Factors

County	Region	Factor
Benton	NW Arkansas	0.90
Carroll	NW Arkansas	0.90
Madison	NW Arkansas	0.90
Washingt	NW Arkansas	0.90
Franklin	Fort Smith	1.00
Logan	Fort Smith	1.00
Scott	Fort Smith	1.00
Sebastian	Fort Smith	1.00
Clark	Hot Springs	1.10
Garland	Hot Springs	1.10
Hot Sprin	Hot Springs	1.10
Montgom	Hot Springs	1.10
Pike	Hot Springs	1.10
Baxter	Springfield Border	0.92
Boone	Springfield Border	0.92
Fulton	Springfield Border	0.92
Marion	Springfield Border	0.92
Faulkner	Little Rock	1.05
Lonoke	Little Rock	1.05
Pulaski	Little Rock	1.05
Saline	Little Rock	1.05
White	Little Rock	1.05
All Other		1.35

REVISED October 1, 2010

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Attachment 3 - Premium Development/Projection
PROPRIETY and CONFIDENTIAL

ARK Mercy One Claims Experience from 7/1/2008 to 3/31/2009
Trended forward to July 1, 2011
Member Month Exposure: 36,606
Average Geographic Factor: 1.00
Average duration was 5.8 months, so utililzation adjusted by 26.2% to reflect average duration
Trend assumed at 10%

Net Paid Dollars	Total
Inpatient	$31.07
Outpatient	$50.70
Physician Services	$60.81
Pharmacy	$18.48
Other	$2.15
Sub Total	$163.20
Back out MH/SA (Mandated Offer Rider):	$1.34
Total Med Expense:	$161.86
Back out Average Age-Gender Factor in Experience:	1.288
Back out average UW load (estimated):	1.163
Male, age 37 Net Paid Claims PMPM:	$108.06
PPACA Adjustments	
Removal of Lifetime Limits:	0.25%
Removal of Annual DME Limit:	0.50%
$0 Preventive Cost Sharing:	2.00%
TOTAL PPACA IMPACT:	2.75%
ADJ Male, age 37 Net Paid Claims PMPM:	$111.03
Minimum Loss Ratio Target:	80%
American Academy of Actuaries 80% C.I. Credibility Adjustment	12%
* Assumes 2,000 average members	
Adjusted Target Loss Ratio:	68%
Projected Premium:	$162.76

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
6 months - 1 yr	Plan A	217.98	217.98	239.78	239.78	217.98	217.98	196.18	196.18	200.54	200.54	294.27	294.27
1 - 4		217.98	217.98	239.78	239.78	217.98	217.98	196.18	196.18	200.54	200.54	294.27	294.27
5 - 18		105.45	105.45	116.00	116.00	105.45	105.45	94.91	94.91	97.02	97.02	142.36	142.36
19 - 24		98.79	134.92	108.67	148.41	98.79	134.92	88.91	121.43	90.89	124.13	133.37	182.14
25 - 29		112.05	161.73	123.26	177.90	112.05	161.73	100.85	145.55	103.09	148.79	151.27	218.33
30 - 34		142.40	205.88	156.64	226.47	142.40	205.88	128.16	185.29	131.01	189.41	192.25	277.94
35 - 39		175.22	244.43	192.74	268.87	175.22	244.43	157.70	219.99	161.20	224.88	236.55	329.98
40 - 44		223.68	271.06	246.05	298.17	223.68	271.06	201.31	243.96	205.79	249.38	301.97	365.94
45 - 49		285.16	317.15	313.67	348.86	285.16	317.15	256.64	285.43	262.34	291.78	384.96	428.15
50 - 54		383.29	382.15	421.61	420.37	383.29	382.15	344.96	343.94	352.62	351.58	517.43	515.91
55 - 59		498.85	454.34	548.74	499.78	498.85	454.34	448.97	408.91	458.94	418.00	673.45	613.36
60 - 64		658.32	542.48	724.15	596.73	658.32	542.48	592.49	488.23	605.65	499.08	888.73	732.35

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
6 months - 1 yr	Plan B	183.39	183.39	201.73	201.73	183.39	183.39	165.05	165.05	168.72	168.72	247.58	247.58
1 - 4		183.39	183.39	201.73	201.73	183.39	183.39	165.05	165.05	168.72	168.72	247.58	247.58
5 - 18		88.72	88.72	97.59	97.59	88.72	88.72	79.85	79.85	81.62	81.62	119.77	119.77
19 - 24		83.11	113.51	91.43	124.86	83.11	113.51	74.80	102.16	76.46	104.43	112.20	153.24
25 - 29		94.27	136.06	103.70	149.67	94.27	136.06	84.85	122.46	86.73	125.18	127.27	183.69
30 - 34		119.81	173.21	131.79	190.53	119.81	173.21	107.83	155.89	110.22	159.36	161.74	233.84
35 - 39		147.42	205.64	162.16	226.21	147.42	205.64	132.67	185.08	135.62	189.19	199.01	277.62
40 - 44		188.19	228.05	207.01	250.86	188.19	228.05	169.37	205.25	173.13	209.81	254.05	307.87
45 - 49		239.91	266.82	263.90	293.50	239.91	266.82	215.92	240.14	220.71	245.48	323.87	360.21
50 - 54		322.46	321.51	354.71	353.66	322.46	321.51	290.22	289.36	296.67	295.79	435.33	434.04
55 - 59		419.69	382.25	461.66	420.47	419.69	382.25	377.72	344.02	386.12	351.67	566.59	516.03
60 - 64		553.85	456.40	609.24	502.04	553.85	456.40	498.47	410.76	509.55	419.89	747.70	616.14

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
6 months - 1 yr	Plan C	154.88	154.88	170.37	170.37	154.88	154.88	139.39	139.39	142.49	142.49	209.09	209.09
1 - 4		154.88	154.88	170.37	170.37	154.88	154.88	139.39	139.39	142.49	142.49	209.09	209.09
5 - 18		74.93	74.93	82.42	82.42	74.93	74.93	67.43	67.43	68.93	68.93	101.15	101.15
19 - 24		70.19	95.86	77.21	105.45	70.19	95.86	63.17	86.28	64.58	88.20	94.76	129.42
25 - 29		79.62	114.91	87.58	126.40	79.62	114.91	71.66	103.42	73.25	105.72	107.48	155.13
30 - 34		101.18	146.29	111.30	160.92	101.18	146.29	91.06	131.66	93.09	134.58	136.60	197.49
35 - 39		124.50	173.68	136.95	191.04	124.50	173.68	112.05	156.31	114.54	159.78	168.07	234.46
40 - 44		158.93	192.60	174.83	211.86	158.93	192.60	143.04	173.34	146.22	177.19	214.56	260.01
45 - 49		202.61	225.34	222.87	247.88	202.61	225.34	182.35	202.81	186.40	207.32	273.53	304.21
50 - 54		272.34	271.53	299.57	298.69	272.34	271.53	245.10	244.38	250.55	249.81	367.65	366.57
55 - 59		354.45	322.83	389.90	355.11	354.45	322.83	319.01	290.54	326.10	297.00	478.51	435.82
60 - 64		467.76	385.45	514.53	423.99	467.76	385.45	420.98	346.90	430.34	354.61	631.47	520.36

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
6 months - 1 yr	Plan D	202.48	202.48	222.73	222.73	202.48	202.48	182.23	182.23	186.28	186.28	273.35	273.35
1 - 4		202.48	202.48	222.73	222.73	202.48	202.48	182.23	182.23	186.28	186.28	273.35	273.35
5 - 18		97.95	97.95	107.75	107.75	97.95	97.95	88.16	88.16	90.12	90.12	132.24	132.24
19 - 24		91.77	125.33	100.94	137.86	91.77	125.33	82.59	112.79	84.43	115.30	123.88	169.19
25 - 29		104.09	150.23	114.50	165.25	104.09	150.23	93.68	135.21	95.76	138.21	140.52	202.81
30 - 34		132.28	191.24	145.51	210.37	132.28	191.24	119.05	172.12	121.70	175.95	178.58	258.18
35 - 39		162.76	227.05	179.04	249.76	162.76	227.05	146.49	204.35	149.74	208.89	219.73	306.52
40 - 44		207.78	251.79	228.56	276.97	207.78	251.79	187.00	226.61	191.16	231.65	280.50	339.92
45 - 49		264.88	294.60	291.37	324.06	264.88	294.60	238.39	265.14	243.69	271.03	357.59	397.71
50 - 54		356.03	354.98	391.64	390.48	356.03	354.98	320.43	319.48	327.55	326.58	480.65	479.23
55 - 59		463.39	422.04	509.72	464.24	463.39	422.04	417.05	379.84	426.31	388.28	625.57	569.76
60 - 64		611.51	503.91	672.66	554.30	611.51	503.91	550.36	453.52	562.59	463.60	825.54	680.28

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
6 months - 1 yr	Plan E	189.85	189.85	208.84	208.84	189.85	189.85	170.87	170.87	174.66	174.66	256.30	256.30
1 - 4		189.85	189.85	208.84	208.84	189.85	189.85	170.87	170.87	174.66	174.66	256.30	256.30
5 - 18		91.84	91.84	101.03	101.03	91.84	91.84	82.66	82.66	84.50	84.50	123.99	123.99
19 - 24		86.04	117.51	94.65	129.26	86.04	117.51	77.44	105.76	79.16	108.11	116.16	158.64
25 - 29		97.60	140.86	107.35	154.94	97.60	140.86	87.84	126.77	89.79	129.59	131.75	190.16
30 - 34		124.03	179.32	136.43	197.25	124.03	179.32	111.63	161.38	114.11	164.97	167.44	242.08
35 - 39		152.61	212.89	167.87	234.18	152.61	212.89	137.35	191.60	140.40	195.86	206.02	287.40
40 - 44		194.82	236.09	214.30	259.69	194.82	236.09	175.34	212.48	179.23	217.20	263.00	318.72
45 - 49		248.36	276.22	273.20	303.84	248.36	276.22	223.52	248.60	228.49	254.12	335.29	372.90
50 - 54		333.83	332.84	367.21	366.12	333.83	332.84	300.44	299.56	307.12	306.21	450.67	449.33
55 - 59		434.48	395.72	477.93	435.29	434.48	395.72	391.03	356.14	399.72	364.06	586.55	534.22
60 - 64		573.37	472.48	630.71	519.73	573.37	472.48	516.03	425.23	527.50	434.68	774.05	637.84

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
6 months - 1 yr	Plan F	172.08	172.08	189.29	189.29	172.08	172.08	154.87	154.87	158.32	158.32	232.31	232.31
1 - 4		172.08	172.08	189.29	189.29	172.08	172.08	154.87	154.87	158.32	158.32	232.31	232.31
5 - 18		83.25	83.25	91.57	91.57	83.25	83.25	74.92	74.92	76.59	76.59	112.38	112.38
19 - 24		77.99	106.51	85.79	117.16	77.99	106.51	70.19	95.86	71.75	97.99	105.29	143.79
25 - 29		88.46	127.67	97.31	140.44	88.46	127.67	79.61	114.91	81.38	117.46	119.42	172.36
30 - 34		112.42	162.53	123.66	178.79	112.42	162.53	101.18	146.28	103.43	149.53	151.77	219.42
35 - 39		138.33	192.96	152.16	212.26	138.33	192.96	124.49	173.67	127.26	177.53	186.74	260.50
40 - 44		176.58	213.99	194.24	235.39	176.58	213.99	158.92	192.59	162.46	196.87	238.39	288.89
45 - 49		225.11	250.37	247.62	275.41	225.11	250.37	202.60	225.33	207.10	230.34	303.90	338.00
50 - 54		302.58	301.69	332.84	331.86	302.58	301.69	272.32	271.52	278.37	277.55	408.48	407.28
55 - 59		393.81	358.68	433.20	394.54	393.81	358.68	354.43	322.81	362.31	329.98	531.65	484.21
60 - 64		519.70	428.25	571.67	471.08	519.70	428.25	467.73	385.43	478.13	393.99	701.60	578.14

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
6 months - 1 yr	Plan G	140.98	140.98	155.08	155.08	140.98	140.98	126.88	126.88	129.70	129.70	190.32	190.32
1 - 4		140.98	140.98	155.08	155.08	140.98	140.98	126.88	126.88	129.70	129.70	190.32	190.32
5 - 18		68.20	68.20	75.02	75.02	68.20	68.20	61.38	61.38	62.74	62.74	92.07	92.07
19 - 24		63.89	87.26	70.28	95.98	63.89	87.26	57.50	78.53	58.78	80.28	86.25	117.80
25 - 29		72.47	104.60	79.72	115.06	72.47	104.60	65.22	94.14	66.67	96.23	97.84	141.20
30 - 34		92.10	133.15	101.31	146.47	92.10	133.15	82.89	119.84	84.73	122.50	124.33	179.76
35 - 39		113.32	158.08	124.65	173.89	113.32	158.08	101.99	142.28	104.26	145.44	152.98	213.41
40 - 44		144.66	175.31	159.13	192.84	144.66	175.31	130.20	157.78	133.09	161.28	195.30	236.67
45 - 49		184.42	205.11	202.87	225.62	184.42	205.11	165.98	184.60	169.67	188.70	248.97	276.90
50 - 54		247.89	247.16	272.68	271.87	247.89	247.16	223.10	222.44	228.06	227.38	334.65	333.66
55 - 59		322.63	293.84	354.89	323.23	322.63	293.84	290.37	264.46	296.82	270.34	435.55	396.69
60 - 64		425.76	350.85	468.34	385.93	425.76	350.85	383.19	315.76	391.70	322.78	574.78	473.64

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	01/13/2011

Comments:

Attachment:

FLESCH 2010 10 11.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	01/13/2011

Comments:

See form schedule filing tab.

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	01/13/2011

Comments:

See form schedule filing tab.

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved	01/13/2011

Bypass Reason: These filings were generated after PPACA and are written to comply with PPACA regs.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Coverletter with Statement of Variability	Approved	01/13/2011

Comments:

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Attachment:

Coverletter 2010 10 11.pdf

		Item Status:	Status Date:
Satisfied - Item:	Redline COC/SOB 2010 10 26	Approved	01/13/2011

Comments:

Redline document to identify changes per your Objections, for your convenience.

Attachments:

SOB Redline 2010 10 25.pdf

COC Redline 2010 10 26.pdf

		Item Status:	Status Date:
Satisfied - Item:	Redline COC 2010 12 16	Approved	01/13/2011

Comments:

Attachment:

COC Redline 2010 12 16.pdf

Department of Insurance
State of Arizona
Life and Health Division
Telephone: (602) 364-2393
Facsimile: (602) 364-2175

JANICE K. BREWER
Governor

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
www.id.state.az.us

CHRISTINA URIAS
Director of Insurance

READABILITY CERTIFICATION

Arizona Administrative Code R20-6-213
Life and Disability Insurance Policy Language Simplification

COMPANY NAME Coventry Health & Life Insurance Company, NAIC # 1137-81973, hereby certifies that the following form(s) comply with the requirements of paragraph (C)(1)(a) of the captioned Rule and achieve a Flesch reading ease test score of:

FORM NUMBER	FLESCH SCORE
CHL-AR-RID-002-10.10	40
CHL-AR-RID-006-10.10	40
CHL-AR-RID-010-10.10	40
CHL-AR-RID-004-10.10	40
CHL-AR-RID-005-10.10	40

Signature of Insurance Company Officer
(rubber stamp, copy or facsimile NOT ACCEPTED)

Steven Robino, Director Regulatory Compliance
Typed Name and Title

October 11, 2010
Date

Certification is required for all policy forms. A photocopy of this specimen is acceptable.

Department of Insurance
State of Arizona
Life and Health Division
Telephone: (602) 364-2393
Facsimile: (602) 364-2175

JANICE K. BREWER
Governor

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
www.id.state.az.us

CHRISTINA URIAS
Director of Insurance

READABILITY CERTIFICATION

Arizona Administrative Code R20-6-213
Life and Disability Insurance Policy Language Simplification

COMPANY NAME Coventry Health & Life Insurance Company, NAIC # 1137-81973, hereby certifies that the following form(s) comply with the requirements of paragraph (C)(1)(a) of the captioned Rule and achieve a Flesch reading ease test score of:

FORM NUMBER	FLESCH SCORE
CHL-AR-COC-001-10.10	40
CHL-AR-OOC-009-10.10	40

Signature of Insurance Company Officer
(rubber stamp, copy or facsimile NOT ACCEPTED)

Steven Robino, Director Regulatory Compliance
Typed Name and Title

October 11, 2010
Date

Certification is required for all policy forms. A photocopy of this specimen is acceptable.

COVENTRY
Health Care of Kansas, Inc.

October 11, 2010

SERFF DOCUMENT

Arkansas Department of Insurance
Health & Life Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: Individual (Coventry*One*) Product, et al
Coventry Health & Life Insurance (NAIC# 1137-81973)

Dear Sir or Madam:

Enclosed, please find ten form filings and one rate filing for Coventry Health & Life Insurance Company. Our intent is to offer this product within the state of Arkansas effective January 1, 2011. These forms are PPACA compliant.

Statement of Variability

All forms contain bracketed variables around Coventry Health Care of Kansas, Inc.("CHC-KS"), a subsidiary of Coventry Health Care, Inc. CHC-KS is intended to be the administrator of this product and is submitting a separate request for a Utilization Review license.

All forms contain bracketed variables around the address, phone, and website information. This is intended to be modifiable as necessary, should this product be administered by another Coventry Health Care company maintaining Arkansas licensure.

Form CHL-AR-COC-001-10.10 contains policy language with in brackets. This is not variable language and will either remain or be deleted in its entirety.

Form CHL-AR-RID-004-10.10 is an Exclusion Rider. The intent of this document is to provide more flexibility for individuals who have health conditions that would normally not meet Coventry's underwriting guidelines. This Rider provides the ability to offer health insurance to individuals and their families rather that simply being declined. The brackets reflect conditions that are disclosed on the application. When identified on this Rider, one or more in combination, will not be covered. The individual has the option of reviewing this offer and accepting or rejecting coverage. The Rider applies individually to an applicant and not universally to the family. The bracketed options within this document represent wording options that will be used exactly as depicted or removed, in any combination.

Form CHL-AR-RID-005-10.10 (TMJ Rider), CHL-AR-RID-006-10.10 (Mental Health Substance Abuse Rider), and CHL-AR-RID-010-10.10 (Hearing Aid Rider) are offers of coverage. Each offer is depicted on the application and may be elected. The rates for such will be defined in the Sales & Marketing materials supplied with the application at the time of sale.

Form CHL-AR-OOC-009-10.10 is the Outline of Coverage. The bracketed variable is where form CHL-AR-SOB-003-10.10 will be inserted in order to appropriately and accurately define the cost share for each service location. An Outline of Coverage will be available for each variable of CHL-AR-SOB-003-10.10 created.

Form CHL-AR-RID-002-10.10 (Pharmacy Rider) and CHL-AR-SOB-003-10.10 (Schedule of Benefits) have a benefit grid for cost share at a Participating Provider or Non-Participating Provider. Coventry certifies that the out of network differential will be no more than 25% greater than the in-network cost share. The bracketed numerical variables are ranges for copayment, deductibles, and coinsurance amounts. The bracketed text is not variable. It will either be left as written or deleted.

Certification of Arkansas Mandated Coverage

Coventry recognizes the mandates Children's Preventive Health Care, Colorectal Cancer Screening, and Prostate Cancer Screening. These are now part of PPACA regulation and as such defined accordingly.

Coventry recognizes the mandate for In-Vitro Fertilization. AR 23-85-137, and Rule 1 indicate this benefit to treated as similar to Maternity coverage. As Maternity coverage is not provided within this Policy, In-Vitro Fertilization is also not covered.

Mandated offerings for Hospice, Mammogram, out-patient service, and psychological examiners have been adapted to standard coverage and subject to the coverage, exclusions, and scope of the Policy like any other service.

Coverage acknowledges the mandate of coverage for Breast Reconstruction/Mastectomy, Dental Anesthesia, Diabetic Supplies/Education, Prescription and Contraceptive drugs, PKU, Loss or Impairment of Speech or Hearing, Newborn coverage, Off-Label Drug Use, and Orthotic and Prosthetic Devices and certifies that each are, if not specifically defined in the Policy, are administered in accordance with the mandate.

The mandate for Mental Health Parity is administered in compliance when the Mental Health Substance Abuse Rider is purchased.

Please contact me with any questions regarding these documents. You can reach me at 866-795-3995, extension 4539, facsimile at 866-701-2517, or via email at jesimms@cvty.com. I look forward to your response.

Respectfully submitted,

Jennifer Simms

Jennifer Simms
Regulatory Compliance Analyst

CoventryOne. Underwritten by Coventry Health and Life Company and administered by [Coventry Health Care of Kansas, Inc.]	PPO Schedule of Benefits [Plan Name] State(s) of Issue: Arkansas	
Benefit	**Insured Responsibility**	
	Participating Providers	**Non-Participating Providers[2]**
[Policy Deductible[4] ([per Calendar Year] [per Contract Year] [Benefit Year]	[Individual:] [$0 - $15,000] [Family:] [$0 - $45,000]	[Individual:] [$0 - $30,000] [Family:] [$0 - $60,000]
[Coinsurance] [and] [Copayment] For All Eligible Expenses (unless otherwise noted)	[$0-$200] [Copayment] [and] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [0%-70%] [Coinsurance] [AD[3]]
[Coinsurance] [Out-of-Pocket[4]] Maximum [(per [Calendar Year] [Contract Year] [Benefit Year])]	Individual: [$0 - $30,000] Family: [$0 - $60,000]	Individual: [$0 - $30,000] Family: [$0 - $60,000]
Physician Office Services[1]		
§ Primary Care Physician Office Visit[1]	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Specialist Physician Office Visit[1]	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ X-ray & Laboratory Services	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Allergy Injections	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ All Other Covered Services - Including but not limited to: Allergy Testing, Therapeutic Injections, Office Surgery	[Same as Physician Office Visit[1]] [$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[Same as Physician Office Visit[1]] [$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Preventive Care		
§ Preventive Care – Including all Preventive Services described in the Covered Services Section of the CoventryOne Policy.	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Immunizations-Adult	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]

§ Immunizations-Pediatric (Up to age 72 months)	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Mammogram [Diagnostic] [and] Routine Screening	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Colonoscopy [Diagnostic] [and] Routine Screening	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Outpatient Laboratory Services		
§ In a Physician's Office	[Same as Physician Office Visit[1]] [$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[Same as Physician Office Visit[1]] [$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ At a Free Standing Facility	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ At a Hospital Facility	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Outpatient Services At Hospital or Free Standing Facility		
§ Radiology	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Diagnostic Services	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
§ Dialysis	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]]*

§ Surgery and Scopes	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year']*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Inpatient Hospital Care		
§ Inpatient hospital care, including semi-private room & board, intensive/coronary care, [maternity care,] x-ray, laboratory, professional services and other facility & ancillary charges.	[$0-$2,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-4,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ Inpatient Rehabilitation *[Limited to [10 – 200] days per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-4,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Urgent Care and Emergency Care Services		
§ Ambulance/Emergency Transportation (Ground or Air)	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*

§ At an Urgent Care Center	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ At a Hospital Emergency Room [(Copayment waived if admitted)]	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ [Emergency Room] [Related Professional Fees]	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Short Term Therapies		
§ Physical Therapy, Occupational Therapy & Speech Therapy *[Limited to [10 – 200] visits [per Therapy] per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ Cardiac and Pulmonary Rehabilitation *[Limited to [10 – 200] visits per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*

§ Partial Day Programs (4 hours or greater) *[Limited to [10 – 200] Visits per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
§ Chiropractic Services/Spinal Manipulation *[Limited to [4 – 200] Visits per [Calendar Year] [Contract Year] [Benefit Year]]*	[Same as Specialist Physician Office Visit] [$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[Same as Specialist Physician Office Visit] [$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Other Services		
[Eye Exam] [including refraction] *[Refraction Services Limited to [1 – 6] exams every [12 – 48] Months]*	[Same as Physician Office Visit[1]] [$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[Same as Physician Office Visit[1]] [$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Injectable Medications (Not listed elsewhere)	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Skilled Nursing Facility *[Limited to [10 – 200] days per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*

Home Health Care *[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] *[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] *[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Hospice § [Inpatient] *[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]* § [Outpatient] *[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] *[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] *[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Durable Medical Equipment § The cost of Phenylketonuria (PKU) or any other Amino and Organic Acid Inherited Disease Food when the food and food products exceeds the income tax credit of $2,400.	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] *[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] *[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Prosthetics & Braces	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] *[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] *[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Organ / Tissue Transplant *[Services provided at approved Coventry Transplant Centers] [only]*	See Appropriate Benefit	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] *[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]* *[See Appropriate Benefit]*

Deleted: *[Not a Covered Benefit]*

Please Note: Maximum Benefit Limits do not guarantee that all services will be approved to the Maximum number allowed under this plan. Coinsurance is based on the contracted allowed amount reimbursed to the provider, if applicable.

In order to receive the maximum benefits, it is Your obligation to ensure that any required Pre-Certification has been obtained. Please see the Pre-Certification requirements outlined in your Certificate of Coverage. [***Failure to do so may result in a [10 - 50%] reduction in benefits [,up to a maximum of [$100 – 500],] for that particular service.]***

1. Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP benefit will apply. If you receive this service from a Specialist, your Specialist benefit will apply.

2. When receiving services from non-participating providers, payment for Covered Services is limited to the lesser of the billed charge or the Out-of-Network rate less applicable Copayment, Coinsurance and/or Deductibles. Please refer to the Certificate of Coverage for additional details.

3. [AD means After Deductible. The [coinsurance] [and] [copayment] requirement applies after You have satisfied the Deductible requirement.]

4. [If you have individual-only coverage, you must satisfy the individual deductible and/or out of pocket maximum before any benefits will be paid. If two or more family members are on the same policy, you must satisfy the entire family deductible and/or out of pocket maximum before any benefits will be paid.]

Premium Payment

Amount of Premium. The monthly premium due for Your coverage under this Policy is stated in the proposal page and may be updated as explained below.

Payment of Premium. The first premium payment(s) is due no later than ten (10) days after the effective date of Your Policy. (For example, Your policy begins July 1, Your premium is due by the 10th of July and must be paid by the 10th of each month.) Premium payments for subsequent months shall be due on the 10th day of each month.

All premium payments must be automatically deducted from either a checking or savings account of a banking institution. If funds are not available at the time of the automatic deduction, You will receive a notice that payment is due directly to Coventry Health & Life Insurance Company. The Plan may impose a service charge when payments are refused and/or returned by the Your financial institution, such as, but not limited to, an account with non-sufficient funds available. Payments should be sent to:

Coventry Health & Life Insurance Company

[P.O. Box 6512
Carol Stream, IL 60197-6512]

Grace Period. You are granted a Grace Period of ten (10) days to make payment of every premium due. This means that if Your premium is not paid on the date that it is due, You must pay it within the following ten (10) days. This Policy will remain in force during this Grace Period. If You do not pay Your total premium by the end of the Grace Period, Your coverage will be retroactively terminated to the date covered by Your last paid premium.

Changes in Premiums. The Plan reserves the right to change Premiums upon ten (10) days written notice to the Policyholder.

- We will automatically change the amount of Your Premium should a birthday place You into the next age classification upon which Premiums are based.

- We may also change the amount of Your Premiums, upon ten (10) days written notice if the Premiums of Your entire age classification are changed.

Effect of Termination.

If Your Coverage under this Policy is terminated, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination.

- Identification cards are the property of the Plan and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.
- Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Grievance and Complaint procedures. The Plan may not terminate the Policy solely for the purpose of effecting the disenrollment of the Insured for either of these reasons.
- If the Insured receives Covered Services after the termination of Coverage, the

Plan may recover the contracted charges for such Covered Services from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

§ Upon the death of an insured, premiums paid for Coverage for the insured for any period beyond the end of the policy month in which the death occurred shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the insurer.

Reinstatement of Coverage

If any renewal Premium is not paid within the time granted the Insured for payment, a subsequent acceptance of Premium by the Plan or by any agent duly authorized by the Plan to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Plan or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Policy will be reinstated upon approval of such application, by the Plan, or lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the Plan has previously notified the Insured in writing of its disapproval of such application.

The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the Insured and the Plan shall have the same rights there under as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date or reinstatement.

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the Policy, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued. If the Plan elects to discontinue offering all health insurance Coverage in the individual market, You will receive a written notice of discontinuation at least one hundred and eighty (180) days before the date the Coverage will be discontinued.

Certificates of Creditable Coverage.

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

Plan may recover the contracted charges for such Covered Services from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

§ Upon the death of an insured, premiums paid for Coverage for the insured for any period beyond the end of the policy month in which the death occurred shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the insurer.

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Certificates of Creditable Coverage.

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

SERFF Tracking Number:	*CVKS-126855093*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*47022*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*CovOne (Individual) Product*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/26/2010	Form	Individual Policy	12/16/2010	CHL-AR-COC-001-10.10.pdf (Superceded)
10/11/2010	Form	Individual Policy	10/26/2010	CHL-AR-COC-001-10.10.pdf (Superceded)
10/11/2010	Form	Schedule of Benefits	10/26/2010	CHL-AR-SOB-003-10.10.pdf (Superceded)
10/27/2010	Rate and Rule	2011 01 01	10/28/2010	2011 01 01 (Revised).pdf (Superceded)
10/11/2010	Rate and Rule	2011 01 01	10/27/2010	2011 01 01.pdf (Superceded)

Health Care Benefits

Arkansas

PREFERRED PROVIDER ORGANIZATION ("PPO")

INDIVIDUAL POLICY

IMPORTANT NOTICE

THIS POLICY, THE APPLICATION AGREEMENT AND ALL ATTACHED RIDERS SHOULD BE READ IN THEIR ENTIRETY.

Carefully check the application agreement and write to Coventry Health & Life Insurance Company at the address listed below, within ten (10) days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application agreement. This application agreement is part of the Policy and the Policy was issued on the basis that answers to all questions and the information shown on the application agreement are correct and complete. You may return this Policy within ten (10) days of its receipt for a full refund of any Premiums paid if, after examining it, You are not satisfied for any reason.

The Insured has the full freedom of choice in the selection of any duly licensed health care professional. This Policy has provisions reducing the amount of Coverage the Insured receives depending on which Physicians or other health care providers are used. Please consult this Policy, the Schedule of Benefits and Provider Directory for more details. If you have any additional questions, please write or call us at:

Coventry Health & Life Insurance Company
[8320 Ward Parkway]
[Kansas City, MO 64114]
[(800) 969-3343]
[www.chckansas.com]

Welcome to Coventry Health & Life Insurance Company!

We are extremely pleased to have You enrolling in our Plan and look forward to serving You. We have built a strong network of area Physicians, Hospitals, and other providers to offer a broad range of services for Your medical needs.

As a Coventry Health & Life Insurance Company Insured, it is important that You understand the way Your Plan operates. This Policy contains the information You need to know about Your Coverage with us.

Please take a few minutes to read these materials so that You are aware of the provisions of Your Coverage. Our Customer Service Department is available to answer any questions You may have about Your Coverage. You can reach them at the number listed in the Schedule of Important Numbers Monday through Thursday, 8:00 a.m. to 6:00 p.m., Friday, 8:00 a.m. to 5:00 p.m. Central Standard Time. You can also check the Plan's website at www.chckansas.com any time for additional information.

We look forward to serving You.

Sincerely,

[Michael Murphy]

Chief Executive Officer

This Policy is guaranteed renewable to age 65 or eligibility for Medicare subject to the termination provisions in Eligibility & Termination. Premium rates may be changed on a class basis.

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Coventry Health & Life Insurance Company
Individual Policy

The Policy between **Coventry Health & Life Insurance Company** (hereafter called the "Plan") and You is made up of:

- This Policy and Amendments;
- Application Form;
- Applicable Riders;
- Provider Directory; and
- Schedule of Benefits.

No person or entity has any authority to waive any Policy provision or to make any changes or Amendments to this Policy unless approved in writing by an Officer of the Plan, and the resulting waiver, change, or Amendment is attached to the Policy. This Policy begins on the date defined in the proposal rate acceptance, and continues until replaced, or terminated. You are subject to all terms, conditions, limitations, and exclusions in this Policy and to all the rules and regulations of the Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of this Policy.

THE POLICY SHOULD BE READ IN ITS ENTIRETY. By carefully reading this Policy and understanding Your relationship to the Plan, You can be an informed participant. You should keep this Policy in a safe place for Your future reference. Many of the provisions of this Policy are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Policy will appear capitalized because they have special meaning and are defined for You. By using these definitions, You will have a clearer understanding of Your Coverage. From time to time, the Policy may be amended. When that occurs, the Plan will provide an Amendment or a new Policy to You.

The Plan is responsible for making benefit determinations in accordance with this Policy and the Plan's agreements with Participating Providers. The Plan does not and will not make medical treatment decisions. Only Providers may make such decisions after meeting with You. If the Plan denies a claim for payment or Pre-Certification of a recommended service, You may request reconsideration of that decision through the Plan's Complaint and Grievance Procedure described in this Policy.

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Definitions

Any capitalized terms listed shall have the meaning set forth below whenever the capitalized term is used in this Policy.

"Activities of Daily Living"

Activities you usually do during a normal day including but not limited to bathing, dressing, eating, maintaining continence, toileting, transferring from bed to chair, and mobility.

"Acute"

Refers to an Illness or Injury that is both severe and of recent onset.

"Administrative Appeal"

An Appeal of a decision that has not been issued for medical necessity or medical appropriateness, but is administrative in nature, for example, appealing a Copayment, Coinsurance, or exclusion associated with a Covered Service.

"Adverse Benefit Determination"

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination may be based in whole or in part on a medical judgment and may also include:

- Any reduction or termination of a benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to not be Medically Necessary or medically appropriate;
- The failure to cover services because they are cosmetic;
- The failure, reduction, or termination regarding the availability and/or delivery of health care services;
- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services; and/or
- The failure, reduction, or termination regarding terms of the contractual relationship between Insured and the Plan.

"Alternate Facility"

A duly-licensed non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received, including without limitation:

- Scheduled surgical services;
- Emergency services;
- Urgent Care Services;
- Prescheduled rehabilitative services;
- Laboratory or diagnostic services;
- Inpatient or outpatient Mental Illness services or Substance Abuse services.

"Amendment"

Any attached written description of additional or alternative provisions to the Policy and/or this Policy. Amendments are effective only when Authorized in writing by the Plan and are subject to

all conditions, limitations and exclusions of the Policy except for those which are specifically amended.

"Ancillary Provider"

A Provider who is not licensed as a Physician or a Hospital.

"Appeal"

An Appeal is a request by You or Your Authorized Representative for consideration of an Adverse Benefit Determination of a service request or benefit that You believe You are entitled to receive.

"Authorized Representative"

An Authorized Representative is an individual authorized in writing or verbally by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for Health Insurance Portability and Accountability Act ("HIPAA") privacy purposes.

"Benefit Maximum"

A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for the Insured in any one Benefit Year. Once a Benefit Maximum is met, no more Covered Services will be provided during the same Benefit Year.

"Benefit Year"

The period of time during which the total amount of annual benefits under Your Coverage is calculated. Your policy may be issued on either a Calendar Year or Contract Year. Please call the customer service number on the back of your ID card to obtain information about Your Benefit Year.

"Calendar Year"

The period of time from January 1 through December 31 inclusive. This is the period during which the total amount of annual benefits under Your Coverage is calculated.

"Chronic Condition"

A health condition that is continuous or persistent over an extended period of time.

"Coinsurance"

Cost-sharing arrangement in which the Insured pays a specified percentage of the cost for a Covered Service.

"Coinsurance Maximum"

The annual limit of a Insured's coinsurance payments for Covered Services, as specified in the Schedule of Benefits"

"Complaint"

Any dissatisfaction expressed by You or Your Authorized Representative regarding a Plan issue.

"Confinement" and "Confined"

An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.

"Contract Year"

The period during which the total amount of yearly benefits under Your Coverage is calculated. The Contract Year is the period of twelve (12) consecutive months commencing on the Effective

Date and each subsequent anniversary.

"Copayment"

Cost-sharing arrangement in which the Insured pays a specified dollar amount as their share of the cost for a Covered Service.

"Cosmetic Services and Surgery"

Services performed to reshape structures of the body in order to alter appearance, to alter the aging process, or when performed primarily for psychological purposes. Cosmetic Services are not needed to correct or substantially improve a bodily function.

"Coverage" or "Covered"

The entitlement by the Insured to Covered Services under this Policy, subject to the terms, conditions, limitations and exclusions of the Policy, including the following conditions: (a) services must be provided when this Policy is in effect; and (b) services must be provided prior to the date that any of the termination conditions listed in this Policy occur; and (c) services must be provided only when the recipient is the Insured and meets all eligibility requirements specified in this Policy; and (d) services must be Medically Necessary.

"Covered Services"

The services or supplies provided to You for which the Plan will make payment, as described in the Policy.

"Custodial Care"

Care is considered custodial when it is primarily for the purpose of helping the Insured with Activities of Daily Living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. This term includes such other care that is provided to the Insured who, in the opinion of the Medical Director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized Insured, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to, respite care and home care which is or which could be provided by family members or private duty caregivers.

"Deductible"

The dollar amount of medical expenses for Covered Services that You are responsible for paying annually before benefits subject to the Deductible are payable under this Policy.

"Dental Services"

Services primarily for the prevention, diagnosis and treatment of diseases and injuries to the oral cavity, the teeth, and their surrounding structures.

"Dependent"

Any member of an Insured's family who meets the eligibility requirements and who is properly enrolled for Coverage under the Agreement and on whose behalf Premiums are paid.

"Designated Transplant Network Facility"

A Hospital appointed as a Designated Transplant Network Facility by the Plan, to render Medically Necessary and medically appropriate services for Covered transplants. You may request a listing that may be amended from time to time, of Designated Transplant Network Facilities from the Customer Service Department listed in the Schedule of Important Numbers.

"Designated Transplant Network Physician"

A Physician appointed as a Designated Transplant Network Physician by the Plan, who has entered into an agreement with a Designated Transplant Network Facility to render Medically

Necessary and medically appropriate services for Covered transplants.

"Durable Medical Equipment"

Medical equipment Covered under this Policy or attached Rider, which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an Illness or Injury, and is appropriate for use in the home. Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of Durable Medical Equipment will be considered Durable Medical Equipment.

"Elective Abortion"

An abortion for any reason other than a spontaneous abortion or to prevent the death of the Insured upon whom the abortion is performed.

"Eligible Expenses"

Charges for Covered Services, incurred while the Policy is in effect.

"Emergency Medical Condition" and "Medical Emergency"

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing the Insured's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part; or
- Inadequately controlled pain.

Some examples of an Emergency Medical Condition include, but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing; or
- Vaginal bleeding during pregnancy.

The Insured may seek medical attention from a Hospital, Physician's office or some other Emergency facility.

"Emergency Services"

Generally, Eligible Expenses for Emergency Services are the charges for the services provided during the course of the Emergency, and when Medically Necessary for stabilization and initiation of treatment. The Emergency Services must be provided by or under the direction of a Physician, and are subject to the exclusions and other provisions set out in this Policy.

"Experimental or Investigational"

A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the Federal Food and Drug Administration ("FDA"); any drug that is classified as an Investigational New Drug ("IND") by the FDA; or any drug that is proposed for off-label prescribing. As used herein, off-label prescribing

means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.

- Off-label prescribing for the treatment of cancer is not considered Experimental or Investigational.
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval.
  - Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered.
- Any health product or service whose effectiveness is unproven or is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts.

"FDA"

Federal Food and Drug Administration.

"Home Health Agency"

An organization that meets all of these tests: (a) its main function is to provide home health care services and supplies; (b) it is federally certified as a home health care agency; and (c) it is licensed by the state in which it is located, if licensing is required.

"Home Health Care Services"

Skilled nursing care and intermittent home health aide services provided in your home through a home health care agency, including physical therapy, speech therapy, occupational therapy, and medical supplies for the treatment of an illness or injury.

"Hospice"

An organization or entity whose primary purpose is to furnish medical services and supplies only to patients who are considered to be terminally ill. The Plan has the right to determine whether a facility is a Hospice facility.

"Hospital"

An institution, operated pursuant to law, which: (a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; and (b) has twenty-four (24) hour nursing services on duty or on call. For the purpose of this definition, a facility that is primarily a place for rest, Custodial Care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

"Illness"

Physical ailment, or disease. For the purpose of this definition, the term Illness does not apply to Mental Illness or Substance Abuse.

"IND"

Investigational New Drug.

"Individual Contract"

A contract for health care services issued to and covering an individual Insured.

"Infertility"

Any medical condition causing the inability or diminished ability to reproduce.

"Infertility Services"

Those services including confinement, treatment or services related to the restoration of fertility or the promotion of conception.

"Injury"

Bodily damage, other than Illness, including all related conditions and recurrent symptoms.

"Inquiry"

Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.

"Insured"

Any Policy Holder or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for Coverage under this Agreement in accordance with its terms and conditions and for whom, or on whose behalf, Premiums have been received and accepted by the Plan.

"Institutional Review Board ("IRB")"

A university or Participating Hospital panel composed of faculty and researchers that evaluates experimental and investigational procedures.

"Maintenance Therapy"

A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition.

"Material Misrepresentation"

Medical or other information not disclosed on the application, or as it relates to Covered Services, which, if it had been disclosed, would have affected the acceptance of coverage, benefits offered or provided and/or Premium charged.

"Maternity Services"

Includes prenatal and postnatal care, childbirth, and any complications associated with pregnancy.

"Medical Director"

The Physician specified by the Plan, or his or her designee, and appropriately licensed in the practice of medicine in accordance with state law, who is responsible for medical oversight programs, including but not limited to Pre-Certification programs.

"Medically Necessary/Medical Necessity"

Medically Necessary means those services, supplies, equipment and facility charges that are not expressly excluded under this Policy and are:

- Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- Necessary to meet Your health needs, improve physiological function and required for a reason other than improving appearance;
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the service;
- Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental

agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;

- Consistent with the diagnosis of the condition at issue;
- Required for reasons other than Your comfort or the comfort and convenience of Your Physician; and
- Not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

"Medical Necessity Appeal"

An Appeal of a determination by the Plan or its designated utilization review organization that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and payment for the service is denied, reduced or terminated.

"Medicare"

Part A and Part B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

"Mental Health and Substance Abuse Designee"

The organization, entity or individual that provides or arranges Covered Mental Health and Substance Abuse services under contract to the Plan.

"Mental Illness" or "Mental Health"

Those conditions classified as "mental disorders" in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders but not including mental retardation.

"NIH"

National Institutes of Health.

"Non-Participating Provider"

A Provider who has no direct or indirect written agreement with the Plan to provide Covered Services to Insureds.

"Officer"

The person holding the office of President and/or CEO or his or her designee.

"Orthotic Appliances"

Orthotic Appliances correct or support a defect of a body form or function.

"Out-of-Pocket Maximum"

The annual limit of an Insured's payments for Covered Services, as specified in the Schedule of Benefits.

"Participating Provider"

A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to the Insured.

"Peer-Reviewed Medical Literature"

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications

that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

"Physician/Practitioner"

Means anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the Degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Physician also means Doctors of Dentistry, Chiropractic and Podiatry when they are acting within the scope of their license.

By use of this term, the Plan recognizes and accepts, to the extent of the Plan's obligation under the Policy, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.

"Plan"

Coventry Health & Life Insurance Company.

"Policy"

This document and Amendments, applicable Riders, Provider Directory, and the Schedule of Benefits together form the Policy.

"Policy Holder"

An applicant, who has elected the Plan's Coverage for himself and eligible Dependents through submission of an application form and in who's name the Policy is issued.

"Post-Service Appeal"

An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

"Pre-Certification"

The Plan has given approval on a Pre-Service request for payment for Covered Services to be rendered by a Participating or Non-Participating Provider. Pre-Certification does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

"Preventive Services"

Shall mean the services set forth in Section 2713(a)(1) of the federal Public Health Service Act. A list of the preventive services covered available on our website at [www.chckansas.com] or will be mailed to you upon request.

"Pre-Existing Condition"

Any condition for which You received medical advice, diagnosis, care, treatment or recommended treatment from an individual licensed or similarly authorized to provide such services under applicable state law within the twelve (12) month period prior to the effective date of your Coverage. A condition may be defined as Pre-Existing whether physical or mental, and regardless of the cause of the condition. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition relating to such information.

"Pre-Existing Condition Exclusion Period"

The period of time for which Covered Services are excluded for a Pre-Existing Condition. The Pre-Existing Condition Exclusion Period begins on Your Effective Date of Coverage.

"Pre-Service Appeal"

An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Pre-Certification.

"Premium"

The monthly fee required from Insured in accordance with the terms of the Policy.

"Prosthetic Devices"

Prosthetic Devices aid body functioning or replace a limb or body part. Prosthetic Devices can be either internally or externally placed.

"Provider"

A Physician, Hospital, or Ancillary Provider or other duly licensed health care facility or practitioner, certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received.

"Provider Directory"

A listing of Participating Providers. Please be aware that the information in the directory is subject to change and will be updated at least annually.

"Reconstructive Surgery"

Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) The definition of Reconstructive Surgery includes the following: reconstructive surgery following a mastectomy, including on the opposite breast to restore symmetry and Prosthetic Devices/implants or reduction mammoplasty; and reconstructive surgery for a Covered newborn.

"Reformation"

Amendment of benefits, Coverage or Premium charged to a level or form different than originally issued to an Insured. The Plan may initiate adjustments to Premium in the event of a Material Misrepresentation that led the Plan to provide Coverage at the original rates quoted.

"Reinstatement"

Means restoring a Policy that has been terminated for example, because of nonpayment of Premiums.

"Rescission or Rescind"

Termination of Your Coverage, retroactive to the effective date of Coverage under this Policy. When Coverage is rescinded, the Plan refunds all Premiums paid, and recovers all payments made on behalf of the applicant. Therefore, the Plan and You are returned to a financial position as if no Coverage had ever been in force. The Plan may initiate this action in the event of a Material Misrepresentation that led to the issuance of Coverage under the Policy.

"Rider"

An Amendment that modifies Covered services and is attached to the Policy. Services provided by a Rider may be subject to payment of additional Premiums.

"Self-Injectables"

Injectable Prescription Drugs as specified in the Plan's formulary list, that are commonly and customarily administered by the Insured according to clinical guidelines used by the Plan.

"Semi-private Accommodations"

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations

are Medically Necessary.

"Service Area"

The geographic area served by the Plan. The Plan's Service Area is subject to change from time to time.

"Skilled Nursing Facility ("SNF")"

A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related services. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily Custodial Care, including training in Activities of Daily Living.

"Substance Abuse"

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

"Therapeutic Injections and IV Infusions"

Prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the Insured.

"Total Disability"

Complete inability of the Insured to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Insured to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. The disability of the Insured must require regular care and attendance by a Physician who is someone other than an immediate family member.

"Urgent Care"

A condition that requires prompt medical attention due to an unexpected Illness or Injury. These conditions may also constitute Emergencies in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

"Urgent Care Appeal"

An Appeal for which a requested service requires Pre-Certification, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of the Insured or the Insured's unborn child; or (b) the Insured's ability to regain maximum function. In determining whether an Appeal involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

"Utilization Review"

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, Pre-Certification, concurrent review, case management, and discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of Coverage.

"We, Us or Our"

Coventry Health & Life Insurance Company.

"You or Your"

The Insured Covered under this Policy.

Acceptance Of This Policy

By selecting Coverage pursuant to this Policy, and by seeking or accepting care or Covered Services, You agree to all of the terms, conditions, and provisions of this Policy, including any Riders and Amendments hereto.

Identification ("ID") Card

Every Insured will receive an ID card. Carry Your ID card with You at all times, and present it every time You request or receive services. The ID card is needed for Providers to bill the Plan for charges other than Copayments, Coinsurance, and non-Covered Services. If You do not show Your ID card, the Providers cannot identify You as an Insured of the Plan, and You may receive a bill for services. If Your ID card is missing, lost, or stolen, contact the Plan's Customer Service Department at [800-969-3343] or through the website at [www.chckansas.com] to obtain a replacement. This information is also listed on the ID card and in the Schedule of Important Numbers. Possession and use of an ID card is not an entitlement to Coverage. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in this Policy.

Health Services Rendered By Participating Providers

An Insured has access to the services of a Participating Provider of their choice within the Provider network when receiving In-Network Covered Services, subject to the terms, conditions, exclusions and limitations of the Policy. Coverage for services described in this Policy and the Schedule of Benefits include services that (a) are Medically Necessary and (b) are provided by or under the direction of a Participating Provider and (c) are Pre-Certified, if required, in advance. The telephone number for Pre-Certification is listed on Your ID card and in The Schedule Of Important Telephone Numbers And Addresses of this Policy. Participating Providers are contractually obligated to file all claims for You.

It is the Insured's responsibility to verify the participation status of Providers. You should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Insured is responsible for verifying the status of the Provider by contacting the Customer Service Department or by checking the Plan's website at [www.chckansas.com].

Coverage for services is subject to timely payment of the Premium required for Coverage under the Plan and payment of the Copayment, Coinsurance and/or Deductible specified for any service. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not the Provider. To verify Coverage of services or Provider participation status, please contact the Customer Service Department.

Notice of Claim

The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits. A Non-Participating Provider may or may not complete and file the claim form for You. Written notice of claim must be submitted to the Plan within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonable.

Claim Forms

You may obtain a Non-Participating claim form from the Plan's Customer Service Department

within fifteen (15) days from the date the Plan receives notice of a claim from You. If a Non-Participating claim form is not provided to You within fifteen (15) days after the Plan receives notice of a claim, You shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting written proof covering the occurrence, character, and extent of loss, within the time fixed for filing a claim.

Proofs of Loss

It is your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of your claim. The Plan requests that You file the Non-Participating Provider claim within ninety (90) days from date of service. However, failure to file the claim within the ninety (90) day period shall not invalidate or reduce the claim, if it was not reasonably possible to provide notice or proof within the ninety (90) days. A claim will not be denied based upon the Insured's failure to submit a claim within the ninety (90) day period. However, claims may not be accepted, except in the absence of legal capacity of the claimant, when You submit proof of loss to the Plan more than twelve (12) months from the date services were provided by the Non-Participating Provider.

Processing of the Filed Claim

We make claim payment decisions based on the information provided on the submitted claim form. We make every effort to process claims upon receipt of the Proof of Loss. All Covered Services payable under the Policy shall be paid not more than thirty (30) days after receipt of the completed claim form, and subject to the Proof of Loss provision of this Policy. If We deny all or part of Your claim, We will send You an Explanation of Benefits form or a letter explaining why it was denied under the terms of the Policy. We will also notify You if additional information is necessary to process the claim.

Non-Participating Provider Fees

Payment for Covered Services provided by Non-Participating Providers is limited to the lesser of the billed charge or the Out-of-Network rates listed below less applicable Copayments, Coinsurance and/or Deductibles. These rates are calculated as a multiple of the Medicare fee schedule for Physicians, Hospitals, outpatient facilities, ancillary providers and other providers. These rates may be adjusted from time to time.

If the amount You are charged for a Covered Service is equal to or less than the Out-of-Network rate, the charge should be completely covered by Your Out of Network benefit, except for any Copayment, Coinsurance, and/or Deductible payments You must make. However, if the amount You are charged is in excess of the Out-of-Network rate for a particular Covered Service, you will be responsible for paying any amounts in excess of the rates listed below, in addition to any applicable Copayment, Coinsurance, and/or Deductible payments.

- **Non-Participating Physician and Other Health Care Professional Fees**
  The Out-of-Network rate is equivalent to 100% of the national average Medicare rate, based on the prior year Resource Based Relative Value Scale ("RBRVS") fee schedule for Physician and other health care profession services, as such services are defined in the American Medical Association's Current Procedural Terminology ("CPT") manual. For Physician and other health care profession services not valued in RBRVS, other Medicare or nationally recognized schedules will be used. For CPT codes developed after the prior year, the rate will be calculated using the assigned Relative Value Units ("RVU") and the prior year Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the First Data Bank Average wholesale Price ("AWP"). Payment for

anesthesia services will be 200% of the prior year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment ("DME"), prosthetics, orthotics and supplies ("DME POS") will be at the prior year DME POS ceiling limit. Payment for Laboratory services will be at the prior year Medicare Clinical Laboratory Fee Schedule. If there is no corresponding rate, as described above, for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.

- **Non Participating Facility Fees**
  The Out-of-Network rate is equivalent to 100% of the Medicare base rate for facility charges. Payment for inpatient services will be based on Diagnosis Related Group ("DRG") rates. Payment for outpatient services will be based on Ambulatory Payment Classification ("APC") rates. Payment for services provided within an ambulatory surgical center will be based on Ambulatory Surgical Center ("ASC") group rates. If there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.

Please note that Physician and Hospital charges typically are not regulated. Billed charges can vary tremendously from one provider to the next, so please make sure you are aware of the billed charge for services you want to receive from Non-Participating Providers.

Pre-Certification

Pre-Certification is required for certain Covered Services as determined by the Plan, such services include Hospital Admissions and related services, selected outpatient procedures, and all transplants. It is the Insured's responsibility to verify that Pre-Certification has been obtained from the Plan prior to receiving Covered Services. A list of current Pre-Certification procedures is provided to You. To request a copy contact the Plan's Customer Service Department's telephone number listed on Your ID card or by visiting the Plan's website at [www.chckansas.com].

Any new, additional or extended services not Covered under the original Pre-Certification will be Covered only if a new Pre-Certification is obtained. All services identified in this Policy are subject to all of the terms, conditions, exclusions and limitations of the Plan, even if the Participating Provider requests the Pre-Certification on behalf of the Insured.

Failure to obtain Pre-Certification will result in a reduction of benefits. To find out the amount of the penalty, please see the Schedule of Benefits. Any penalty applied does not apply to the Out-of-Pocket Maximum, the Deductible or Coinsurance amount. It is the Insured's responsibility to verify that Pre-Certification has been obtained before receiving services.

It is important to note that under the terms of the Plan, Pre-Certification only determines medical necessity and appropriateness, all other terms of the Plan are then applied. If the Plan Pre-Certifies Covered Services, the Plan shall not subsequently retract the Pre-Certification after the Covered Services have been received, or reduce payment unless: (1) Such Pre-Certification is based on a Material Misrepresentation or omission about the Insured's health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) the Insured's Coverage under the Plan terminates before the health care services are provided.

Second Opinion Policy

An Insured may seek a second medical opinion or consultation from any Provider. An Insured

should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits and subject to the terms, conditions, exclusions and limitations of the Policy.

Copayments, Coinsurance and Deductibles

You are responsible for paying Copayments to Providers at the time of service. The Provider may bill You at a later time for the Coinsurance amounts that are Your responsibility under the terms of the Plan as determined by the contracted rates that have been established between the Plan and the Participating Providers or as determined by the Plan's Non-Participating Provider fee schedule when services are rendered by a Non-Participating Provider. You must meet the applicable Deductible, as described in your Schedule of Benefits, before benefits will be payable to Providers on Your behalf. Specific Copayments, Coinsurance amounts and Deductibles are listed in the Schedule of Benefits. A Copayment is defined as a dollar amount, while Coinsurance is typically defined as a percentage of Eligible Expenses.

How to Contact The Plan

Throughout this Policy, You will find that the Plan encourages You to contact the Plan for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact the Plan at the telephone number or website on the back of Your ID card.

Telephone numbers and addresses to request review of denied claims, register Complaints, place requests for Pre-Certification, and submit claims are listed in the Schedule of Important Telephone Numbers And Addresses included in this Policy.

Participating Provider Hold Harmless

Participating Providers agree that in no event, including but not limited to nonpayment by the Plan or intermediary, insolvency of the Plan or intermediary, or breach of this Policy, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against the Insured or a person, other than the Plan or intermediary, acting on behalf of the Insured for services provided pursuant to this Policy. This Policy shall not prohibit the Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the EOC, or fees for non-Covered Services delivered on a fee-for-service basis to You. The provider hold harmless provision shall not prohibit a Provider and You from agreeing to continue services solely at Your expense, as long as the Provider has clearly informed You that the Plan may not cover or continue to cover a specific service or services. Except as provided herein, this provision does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing Coverage to You.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Policy. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Illness or Substance Abuse, or Mental Illness does not mean that the procedure or treatment is Covered under the Policy. The Plan shall have the right, subject to Your rights under this Policy, to interpret the benefits of this Policy and attached Riders, and other terms, conditions, limitations and exclusions set out in the Policy in making factual

determinations related to the Policy, its benefits, and the Insured; and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw or add benefits to, or terminate this Plan. Any termination of the Policy must be in accordance with Eligibility & Termination of this Policy. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

Policy Holder Eligibility - To be eligible to be enrolled You must:

- Meet any eligibility criteria specified by the Plan;
- Be under the age of 65 and not eligible for Medicare;
- Pay required premiums when due; and
- Complete and submit to the Plan such application or forms that the Plan may reasonably request.

Dependent Eligibility - To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

Be the lawful Spouse of the Policy Holder or be a child of the Policy Holder or the Policy Holder's Spouse including:

- Children up to age twenty-six (26) who are either the birth children of the Policy Holder or the Policy Holder's Spouse or legally adopted by or placed for adoption with the Policy Holder or Policy Holder's Spouse;
- Children up to age twenty-six (26) for whom the Policy Holder or the Policy Holder's Spouse is required to provide health care Coverage pursuant to a Qualified Medical Child Support Order;
- Children up to age twenty-six (26) for whom the Policy Holder or the Policy Holder's Spouse is the court-appointed legal guardian;
- Coverage will be extended for children age twenty-six (26) who meet the Eligibility requirements, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Policy Holder or the Policy Holder's Spouse for support and maintenance, provided that: the onset of such incapacity occurred before age twenty-six (26), proof of such incapacity is furnished to the Plan by the Insured upon enrollment of the Dependent child or at the onset of the Dependent child's incapacity prior to reaching the limiting age and annually thereafter;

Service Area – The Service Area includes all counties within the State of Arkansas.

Medical Underwriting - Eligibility for Coverage under this Policy is based on health-related factors, excluding genetic testing. An evaluation of the applicant's medical history will determine acceptance and final Premium for this Coverage.

- In order to determine acceptance the Plan will review the Medical Questionnaire information from the Application agreement.
- If minor clarification is needed the Plan will send an additional questionnaire and ask You to complete the form.
- If more detailed information is needed additional medical information may be requested from the Provider listed on the Application agreement Medical Questionnaire or additional information provided by You.
- If we have not received the information requested within thirty (30) days, the application will be deemed denied.

Persons Not Eligible to Enroll

- A person who fails to meet the eligibility requirements specified in this Policy shall not be eligible to enroll or continue enrollment with the Plan for Coverage under this Policy.

- A person whose Coverage was terminated due to a violation of a material provision of this Policy shall not be eligible to enroll with the Plan for Coverage under this Policy.

- A person who is on active duty in the armed forces of any country shall not be eligible to enroll.

- Except as otherwise specifically stated in the Policy or as required by law, initial enrollment is limited to individuals who are not eligible for Title XVIII of the Social Security Act 49 Stat. 620 (1935), 42 USCA 301 as amended (Medicare) or any similar program sponsored by the federal government or a state government.

  If you become eligible for Medicare while you are covered under this Policy, you should enroll for and maintain coverage under both Medicare Part A and Part B.

  When you reach age 65, we will assume that you have enrolled in Medicare Part A and Part B.

Special Enrollment Due to New Dependent Eligibility - Subject to the conditions set forth below, a new Dependent of the Policy Holder or the Policy Holder's Covered Spouse may enroll in the Plan if the Policy Holder or the Policy Holder's Covered Spouse has acquired a Dependent through marriage, birth, adoption or placement for adoption.

- New Spouse Due to Marriage. Subject to the Medical Underwriting provisions noted above, the Policy Holder's new Spouse may enroll at any time after marriage.

- New Dependents Due to Birth. A newborn child born to the Policy Holder or the Policy Holder's Covered Spouse may be Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first five (5) days from the date of birth or until the mother is discharged, whichever is earlier. For Coverage to continue beyond the first five (5) days, an Application agreement to enroll the newborn must be received within ninety (90) days from the date of birth, and subject to all eligibility requirements.

- New Dependents Due to Adoption. A child who becomes a Dependent as a result of adoption or placement for adoption, may enroll within sixty (60) days from the date of adoption or placement for adoption.

- If application to enroll the new Dependent is submitted beyond the time limits noted above, the application will be subject to the medical underwriting provisions.

Notwithstanding the above, a common law Spouse qualifies as a Spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.

Effective Date. Coverage shall become effective on the Effective Date indicated in the notification of acceptance the Plan sends You. You will receive such notification when the Plan receives a completed Application Form and approves the enrollment. You will not be enrolled until You receive such notice. Your payment of the applicable premium is considered to be your acceptance of Coverage.

Notification of Change in Status. You must notify the Plan of any changes in Your status within thirty (30) days of the event. Submit this notice to the Plan's Customer Service Department at [(800) 969-3343] or through the website at [www.chckansas.com]. Events qualifying as a change in status and requiring notice include, but are not limited to, change in name or address, and Medicare eligibility. We should be notified within a reasonable time of the death of the Insured.

Termination of Policy and Renewal This Policy shall be renewable at the option of the Insured, except as described immediately below. Non-renewal shall not be based upon the deterioration of mental or physical health of the Insured under this Policy.

Your Coverage shall terminate if any one of the following events occurs:

- **Loss of Eligibility.** If You no longer meet the eligibility requirements set forth in this Policy, Your coverage shall end at 11:59 p.m. on the date You no longer meet the eligibility requirements.

- **Rescission of Coverage.** Coverage for an Insured under this Policy may be canceled, Reformed or Rescinded based on medical or other enrollment or eligibility information received which was not properly or completely disclosed, or was falsely disclosed in Your Application agreement, prior to contracting or enrollment. NOTE: If an Insured's coverage is Rescinded, as described in this section, coverage will be termed back to the effective date and the Plan will seek recovery of all payments made on the Your behalf. Therefore, both the Plan and the Insured will be returned to a financial position as if no coverage had ever been in force. The Plan may initiate this action in the event that, among other possible reasons, there is a Material Misrepresentation that led the Plan to provide coverage. However, an Insured's coverage will not be Rescinded due to improper disclosure on the Application agreement after coverage has been in effect for two years. This exception does not apply in the case of fraudulent misrepresentation.

- **Non-payment of Premiums.** You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the ten (10) day grace period, you will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the ten (10) day grace period.

- **Change in Status.** In the event You change Your place of residence within Our Service Area, You will be offered an opportunity to enroll in a new Policy. [If you move outside Our Service Area you will be notified within thirty (30) days, of your Policy termination.]

- **Fraud.** You participate in fraudulent or criminal behavior, including but not limited to:

  - √ Performing an act or practice that constitutes fraud or Material Misrepresentation of facts including, but not limited to using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled.

  - √ Allowing any other person to use Your identification card to obtain services. If the Insured allows any other person to use his/her identification card to obtain services, the Coverage of the Insured will be terminated.

  - √ Knowingly misrepresenting, omitting or giving false information on any Policy forms and medical questionnaire.

Premium Payment

Amount of Premium. The monthly premium due for Your coverage under this Policy is stated in the proposal page and may be updated as explained below.

Payment of Premium. The first premium payment(s) is due no later than ten (10) days after the effective date of Your Policy. (For example, Your policy begins July 1, Your premium is due by the 10th of July and must be paid by the 10th of each month.) Premium payments for subsequent months shall be due on the 10th day of each month.

All premium payments must be automatically deducted from either a checking or savings account of a banking institution. If funds are not available at the time of the automatic deduction, You will receive a notice that payment is due directly to Coventry Health & Life Insurance Company. The Plan may impose a service charge when payments are refused and/or returned by the Your financial institution, such as, but not limited to, an account with non-sufficient funds available. Payments should be sent to:

Coventry Health & Life Insurance Company

[P.O. Box 6512
Carol Stream, IL 60197-6512]

Grace Period. You are granted a Grace Period of ten (10) days to make payment of every premium due. This means that if Your premium is not paid on the date that it is due, You must pay it within the following ten (10) days. This Policy will remain in force during this Grace Period. If You do not pay Your total premium by the end of the Grace Period, Your coverage will be retroactively terminated to the date covered by Your last paid premium.

Changes in Premiums. The Plan reserves the right to change Premiums upon ten (10) days written notice to the Policyholder.

- We will automatically change the amount of Your Premium should a birthday place You into the next age classification upon which Premiums are based.

- We may also change the amount of Your Premiums, upon ten (10) days written notice if the Premiums of Your entire age classification are changed.

Effect of Termination.

If Your Coverage under this Policy is terminated, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination.

- Identification cards are the property of the Plan and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.
- Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Grievance and Complaint procedures. The Plan may not terminate the Policy solely for the purpose of effecting the disenrollment of the Insured for either of these reasons.
- If the Insured receives Covered Services after the termination of Coverage, the

Plan may recover the contracted charges for such Covered Services from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

§ Upon the death of an insured, premiums paid for Coverage for the insured for any period beyond the end of the policy month in which the death occurred shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the insurer.

Reinstatement of Coverage

If any renewal Premium is not paid within the time granted the Insured for payment, a subsequent acceptance of Premium by the Plan or by any agent duly authorized by the Plan to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Plan or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Policy will be reinstated upon approval of such application, by the Plan, or lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the Plan has previously notified the Insured in writing of its disapproval of such application.

The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the Insured and the Plan shall have the same rights there under as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date or reinstatement.

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the Policy, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued. If the Plan elects to discontinue offering all health insurance Coverage in the individual market, You will receive a written notice of discontinuation at least one hundred and eighty (180) days before the date the Coverage will be discontinued.

Certificates of Creditable Coverage.

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Pre-Certified, if Pre-Certification is required, (3) not expressly excluded in the list of Exclusions and Limitations section as set forth in this Policy, and (4) incurred while the Insured is eligible for Coverage under the Plan. It is the Insured's responsibility to verify whether a Covered Service requires Pre-Certification and should always reference the Schedule of Pre-Certification Requirements prior to receiving Covered Services. You should not assume that a Participating Provider has already accomplished the Pre-Certification.

The following section, **Schedule of Covered Services**, provides the services and supplies Covered under this Policy. The schedule is provided to assist You with determining the level of Coverage, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in this Policy. If a service is not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service.

Please note that the Covered Services in the schedule below are subject to all applicable Exclusions and Limitations of this Policy.

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Allergy	Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	**Exclusions:** See Exclusion Section relating to allergy services.
Ambulance (air and ground)	Coverage is provided for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency services can be rendered.	**Exclusions:** See Exclusion Section regarding ambulance services.
Blood and Blood Products Processing	Coverage is provided for administration, storage, and processing of blood and blood products in connection with services Covered under this Policy.	**Exclusions:** See Exclusion Section regarding blood and blood products.
Breast Reconstruction	Coverage is provided for breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy resulting from diagnosed cancer. As required by the Women's Health and Cancer Rights Act ("WHCRA"), if You elect breast reconstruction after a Covered mastectomy, benefits will be provided for (1) augmentation and reduction of the affected breast, (2) augmentation or reduction on the opposite breast to restore symmetry, (3) prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction.	**Exclusions:** See Exclusion Section regarding Reduction or Augmentation Mammoplasty.
Cardiac Rehabilitation Services	Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Chemotherapy	Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer.	**Limitations:** Chemotherapy benefit is subject to the Plan's Experimental and Investigational exclusion.
Colorectal Cancer Screening	Coverage is provided for a colorectal cancer exam and related laboratory testing for any asymptomatic Insured pursuant to the Plan's criteria, which are in accordance with the current American Cancer Society and U.S. Preventive Services Taskforce guidelines.	
Contraceptive Devices	Coverage is provided for contraceptive implants, diaphragms, and IUDs (including their insertion and removal), as specifically provided in the Schedule of Benefits. Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider.	
Dental Services	Coverage is provided for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if: (1) The provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and (2) The patient is: (A) A child under seven (7) years of age who is determined by two (2) dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; (B) A person with a diagnosed serious mental or physical condition; or (C) A person with a significant behavioral problem as determined by the Insured's physician. If a person is covered under both this Plan and a benefit plan that provides dental benefits, the health benefit plan that includes dental benefits is the primary payer.	Limited benefit. **Exclusions:** See Exclusions Section regarding dental services.
Dermatological Services	Coverage is provided for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Dialysis	Coverage is provided for hemodialysis and peritoneal services provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.	
Diabetic Supplies	Coverage includes Plan approved glucose meters and self-management training used in connection with the treatment of diabetes.	**Limitations:** Disposable insulin syringes, glucose strips, and lancets are Covered under the pharmacy Rider. If a pharmacy Rider is not purchased, Coverage for this benefit will be provided under this Policy.
Durable Medical Equipment ("DME")	Coverage is provided when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member. The wide variety of DME and continuing development of patient care equipment makes it impractical to provide a complete listing of Covered or non-Covered equipment here. Therefore, the Plan may approve requests on a case by case basis. The Plan may rent or purchase DME.	Upgrades to equipment are the responsibility of the Insured. **Exclusions:** See Exclusions Section regarding DME Coverage.
Emergency Services	Coverage is provided for health services and supplies furnished or required to screen and stabilize an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. The determination of Covered Services for services rendered in an emergency facility is based on the prudent layperson standard, along with those relevant symptoms and circumstances that preceded the provision of care. Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and Pre-Certification is not required.	You should notify Your Physician and the Plan within 48 hours of admission or the next business day or as soon as physically able.
Eye Glasses and Corrective Lenses	Not a Covered Service, except for the first pair of eyeglasses or corrective lenses following cataract surgery	**Exclusions:** See Exclusions Section regarding eyeglasses and contact lenses.
Genetic Counseling and Studies	Coverage is provided for genetic counseling and genetic studies only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities and the testing will alter the	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	outcome of treatment.	
Gynecological Examinations	Coverage is provided for routine well-woman examinations, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society and the U.S. Preventive Services Taskforce Guidelines.	
Hearing Screenings	Coverage is provided for a hearing screening to determine hearing loss.	
Home Health Care Services	Coverage is provided when all of the following requirements are met: (1) the service is ordered by a Physician; (2) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, respiratory therapist, or occupational therapist; (3) part-time intermittent services are required; (4) a treatment plan has been established and periodically reviewed by the ordering Physician; and (5) the agency rendering services is licensed by the State of location.	**Exclusions:** See Exclusions Section regarding Home Services.
Hospice	Coverage is provided for hospice care rendered by a Provider for treatment of a terminally ill Insured when ordered by a Physician. Care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the Illness, and guidance and assistance during the Illness for the purpose of preparing the Insured and the Insured's family for a terminal Illness.	
Inpatient Hospital Care	Coverage includes semi-private accommodations and associated professional and ancillary services. Certain services rendered during the Insured's Confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits and Schedule of Exclusions.	**Exclusions:** See Exclusions Section regarding Private inpatient room.
Laboratory and Pathology Services	Coverage is provided as listed in the Schedule of Benefits.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Newborn Care	The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, Reconstructive Surgery for the treatment of medically diagnosed congenital defects or birth abnormalities. Coverage is provided for all eligible newborns to be tested or screened for phenylketonuria ("PKU") and such other common metabolic or genetic diseases. Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.	.
Nutritional Counseling	Coverage is provided when provided by a registered dietician and when the Insured is diagnosed with diabetes.	
Oral Surgery and Diseases of the Mouth	Coverage includes only oral surgical services limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect. Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin.	**Exclusions:** See Exclusions Section regarding oral surgery and dental services.
Orthotic Devices	Coverage is provided for the initial purchase of Orthotic Appliances following the onset or initial diagnosis of the condition for which the device is required. Coverage is provided for Orthotic Appliances, splints and braces, including necessary adjustments to shoes to accommodate braces. Shoe inserts will be Covered only if the Insured has diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace.	**Exclusions:** See the Exclusions Section regarding Orthotic Appliances.
Osteoporosis	Coverage is provided for services related to diagnosis, including central bone density tests; medically necessary treatment and appropriate management of osteoporosis. In determining medical appropriateness, due consideration shall be given to peer-reviewed medical literature.	
Outpatient Diagnostic Services	Coverage is provided for services and supplies for outpatient diagnostic services provided under the direction of a Provider at a Hospital or Alternate Facility. Coverage for testing pregnant women and children for lead poisoning shall be covered as any	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	other outpatient diagnostic service. Also covered is human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing for A, B, and DR antigens.	
Outpatient Surgery	Coverage is provided for services and supplies for outpatient surgery provided under the direction of a Provider at a Hospital or Alternate Facility.	
Outpatient Therapy Services	Coverage is provided for short-term outpatient therapy services that are expected to result in significant functional improvement of the Insured's condition, limited to physical therapy, occupational therapy, and speech therapy. Speech therapy is covered for loss or impairment of speech or hearing. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and which fall within the scope of his/her license or certification.	**Exclusions:** See Exclusions Section.
PKU or any other Amino and Organic Acid Inherited Disease Formula/Food	Coverage is provided for formula and/or food used for PKU or any other amino and organic acid inherited disease that is recommended by a Provider as determined by the Plan to be Medically Necessary.	
Physician Services	Coverage is provided for Physician Services, including but not limited to, office visits, Hospital visits, consultations, and interpretation of tests.	
Preventive Services	The preventive health services referenced below shall be covered in full and are not subject to cost-sharing requirements (including co-payments, co-insurance and deductible), in a manner consistent with Section 2713 of Federal H.R. 3590. A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force; B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention ("ACIP - CDC"); C. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	D. Additional preventive care and screenings for women (including breast cancer screening and mammography screenings) not described in paragraph (A). A list of the preventive services covered under this paragraph is available on our website at [www.chckansas.com] or will be mailed to You upon request. You may request the list by calling the Customer Service number on Your identification card.	
Prosthetic Devices	Coverage is provided for the initial purchase of Prosthetic Devices following the onset or initial diagnosis of the condition for which the device is required. For Prosthetic Device placements requiring a temporary and then a permanent placement only one (1) temporary device will be Covered. Coverage is provided for Prosthetic Devices, including but not limited to, purchase of artificial limbs, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. Coverage is provided for external Prosthetic Devices that are used in lieu of surgery for breast reconstruction due to a mastectomy. Coverage will be provided for replacement of Prosthetic Devices, which become non-functional and non-repairable due to: (1) A change in the physiological condition of the Insured; (2) Irreparable wear or deterioration from day-to-day usage over time of the device; or (3) The condition of the device requires repairs and the cost of such repairs would be greater than the cost of a replacement device. Prosthetics will be replaced for documented growth in a child requiring replacement. Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.	Coverage for Prosthetic devices will be subject to the benefit limit as expressed in the Schedule of Benefits. Coverage for internal prosthetic devices, including but not limited to, artificial heart valves, artificial joint appliances, orthopedic implants, will not be subject to the benefit limit. **Exclusions:** See Exclusions Section regarding Prosthetic Devices.
Pulmonary Rehabilitation Services	Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.	
Radiation Therapy	Coverage is provided for standard radiation therapy.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Radiology	Coverage is provided as determined by the Plan.	
Reconstructive Surgery	Services are limited to the surgical correction of congenital birth defects or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment.	**Limitations:** Coverage for reconstructive surgery for a congenital birth defect shall be Covered only for dependent children [through age eighteen (18)]. **Exclusions:** See Exclusions Section regarding Cosmetic Services and Surgery.
Rehabilitation Services and Supplies	Coverage is provided for short-term inpatient or outpatient rehabilitation services which are expected to result in significant functional improvement of the Insured's condition. Rehabilitation services must be performed by a Provider, including a free standing rehabilitation facility.	**Exclusions:** See Exclusions Section regarding rehabilitation services and supplies.
Sleep Studies	Covered Services.	**Exclusions:** See Exclusion Section regarding sleep studies.
Skilled Nursing Facility Services	Coverage is provided for Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of a Provider in a Skilled Nursing Facility. Services rendered in a Skilled Nursing Facility are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan.	**Limitations:** Coverage in a Skilled Nursing Facility may be subject to a Benefit Year limitation as specified in the Schedule of Benefits. Certain ancillary services rendered during the Insured's Confinement are subject to separate benefit restrictions and/or Insured responsibilities as described elsewhere in this Policy or in the Schedule of Benefits.
Spinal Manipulation Services	The following services are Covered when they are delivered by a duly licensed Provider acting within the scope of his or her license: • Initial Examinations Coverage includes the initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder. This examination is performed to determine the nature of the Insured's problem. Examinations should be limited to the portion of the body in which the symptoms are being experienced. A more thorough examination of the bodily systems	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	may be done if appropriate clinical indications are present and documented. Vital signs should be included in examinations when appropriate. • Subsequent Office Visits This may include an adjustment, a brief examination and other Medically Necessary services. • Re-examination This is performed to assess the need to continue, extend, or change the course of treatment. A re-evaluation may be performed during a subsequent office visit.	
Sterilization (voluntary)	Covered Service.	**Exclusions:** See Exclusions Section regarding reversal of sterilization.
Therapeutic Injections and IV Infusions.	Coverage is provided for Injectable and Self-Injectable medications when FDA-approved, medically appropriate subject to the Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan.	**Limitations:** Certain Self-Injectable medications may be Covered by a pharmacy Rider and therefore excluded from the medical benefit. **Exclusions:** See Exclusions Section regarding Prescription medications.
Transplants	Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Coventry Transplant Network participating facility and the recipient is an Insured. Donor screening tests are Covered and when performed at a Coventry Transplant Network participating facility. If not Covered by any other source, the cost of any care, including complications up to 90-days, arising from an organ donation by a non-Insured when the recipient is an Insured will be Covered for the duration of the Policy. Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants.	**Exclusions:** See Exclusions Section regarding transplant services.

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	The cost of any care, including complications, arising from an organ donation by the Insured when the recipient is not an Insured is excluded. If the Insured resides more than one hundred-fifty (150) miles from the transplant facility, reimbursement for travel will be Covered. Travel expenses may include the lodging for one family member or responsible adult. Lifetime limitation for travel and lodging are determined by the Plan.	
Urgent Care Services	Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention. If possible, please contact Your Physician in the event Urgent Care services are/were rendered. Your Physician is available to provide guidance and direction in situations that may require Urgent Care. However, failure to notify Your Physician will not result in denial of Coverage. If Medically Necessary follow-up care related to the initial Urgent Care service is required, you should contact and coordinate with Your Physician.	
Vision Services	Coverage is provided for eye examination to include, if Medically Necessary, medical history; evaluation of visual acuity; external examination of the eye; binocular measure; ophthalmoscopic examination; medication for dilating pupils and desensitizing the eyes for tonometry; summary and findings, a determination as to the need for correction of visual acuity, prescribing lenses, if needed.	**Exclusions:** See exclusions section regarding Vision Services.

[Pre-Existing Conditions Limitation

Pre-Existing Conditions may affect Your premium rate, may result in denial of Your application, or We may deny Coverage for them for a period of time after Your effective date. If You are accepted for Coverage, Your premium rate will be calculated to include any Pre-Existing Condition that You disclosed on Your enrollment form, and such conditions will be Covered under the terms of Your Policy beginning on Your effective date. Any Pre-Existing Condition(s) that is not disclosed on Your enrollment form will be excluded from Coverage for a period not longer than twelve (12) months after Your effective date .

Pre-Existing Condition Exclusions shall not apply to any Covered Person under the age of 19.]

Non-Duplication of Coverage Under Certain Laws

Motor Vehicle Coverage

This Policy will always be secondary to any state no-fault law that requires motor vehicle liability policies to provide person injury protection insurance for the insured and any passengers. Individual automobile "no fault" medical payment contracts that provide personal injury protection or no-fault benefits in excess of the minimum limits required by state law will remain primary to the limit or extent of the personal injury protection benefit provided in the automobile insurance policy. The plan benefits will be reduced by the amount of the personal injury protection coverage paid for by any such no-fault law or limit provided in the applicable automobile insurance policy. If a vehicle insurance policy has a provision providing personal injury protection coverage, whether required by law or not, such coverage will be primary over coverage provided by this Policy. The Insured agrees to furnish information to the Plan concerning any applicable personal injury protection insurance upon request.

Right of Recovery

The Plan has the right to correct benefit payments that are made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payments if any underpayments have been made.

General Exclusions

Unless otherwise stated in this Policy, the following items are excluded from Coverage:

1) Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Policy;

2) Any service or supply that is not Medically Necessary;

3) Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service;

4) Any service or supply for which You have no financial liability or that was provided at no charge; those services for which the Insured has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Policy;

5) Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;

6) Court-ordered services or services that are a condition of probation or parole;

7) Those services otherwise Covered under the Policy, but rendered after the date Coverage under the Policy terminates, including services for medical conditions arising prior to the date individual Coverage under the Policy terminates; and

8) Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as the Insured, or rendered by a person who is a member of the Insured's family, including Spouse, brother, sister, parent, step-parent, child or step-child.

Specifically excluded services include, but are not limited to, the following:

1) **Acupuncture -** Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not Covered;

2) **Allergy Services -** Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;

3) **Alternative Therapies** - Alternative therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;

4) **Ambulance Service -** Non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Insured;

5) **Augmentative Communication Devices –** Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Insureds;

6) **Autopsy** - Those services and associated expenses related to the performance of autopsies, and also post-mortem genetic studies;

7) **Behavior modification;**

8) **Biofeedback;**

9) **Blood and Blood Products - The cost of whole blood and blood products replacement to a blood bank;**

10) **Blood Storage** - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;

11) **Braces and supports needed for athletic participation or employment;**

12) **Charges resulting from Your failure to appropriately cancel a scheduled appointment;**

13) **Cochlear Implants** and related services;

14) **Cosmetic Services and Surgery** - Those services, associated expenses, or complications resulting from Cosmetic Surgery, which alters appearance but does not restore or improve impaired physical function. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes;

15) **Counseling Services** and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;

16) **Custodial Care**, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists the Insured in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services;

17) **Dental Services -** Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the surgical treatment of temporomandibular joint disorder ("TMJ"), whether the services are considered to be medical or dental in nature except as provided in the "Covered Services" Section of this Policy. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). The diagnosis and treatment for TMJ and craniomandibular joint disease is not Covered unless by an attached Rider. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;

    Also excluded from coverage are dental services when such services are directly related to an accidental injury. This includes but is not limited to treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an accidental injury.

    Removal of teeth, including any prophylactic extractions, as a complication of radionecrosis is not a Covered Service

18) **Dental Surgery and Implants** - Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded.;

19) Medical services and expenses incurred for learning disabilities, **developmental delays**, mental retardation, and autistic disorders.

20) **Durable Medical Equipment ("DME")** - Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home blood pressure monitoring devices; home oximetry units; home traction units; replacement for changes due to obesity; preventive or routine maintenance due to normal wear and tear or negligence of items owned by the Insured; personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services;

21) **Educational Services** Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;

22) **Equipment** or services for use in altering air quality or temperature;

23) Educational testing or psychological testing, unless part of a treatment program for Covered Services;

24) **Elective or Voluntary Enhancement -** Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition,

service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan;

25) **Eligible Expenses -** Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;

26) **Enteral Feeding Food Supplement -** The cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

27) **Examinations** - Unless otherwise Covered under the Covered Services Section, those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, travel, employment, insurance, marriage or adoption. Also excluded are services relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type;

28) **Exercise equipment**, hot tubs and pools;

29) **Eye Glasses and Contact Lenses** - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;

30) **Food or food supplements ,** regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease;

31) **Foot Care** – Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Insured;

32) **Foreign Travel -** care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services;

33) **Growth Hormone –** Growth hormone therapy for any condition, except in children less than 18 years of age who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan;

34) **Hair analysis, wigs and hair transplants -** Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Provider;

35) **Home services to help meet personal, family, or domestic needs;**

36) **Health and Athletic Club Membership -** Any costs of enrollment in a health, athletic or similar club;

37) **Hearing Services and Supplies** - Those services and associated expenses for hearing aids, cochlear implants, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests, unless Covered by an attached Hearing Aid Rider;

38) **Household Equipment and Fixtures -** Purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;

39) **Hypnotherapy and Hypnosis;**

40) **Immunizations** unless specifically covered under the Policy, including but not limited to immunizations required for travel, school, work-related, Anthrax vaccine and Lyme Disease vaccine. Also excluded are examinations and testing in connection with insurance, obtaining employment, specifically for the purpose of entering school, participating in extracurricular school activities, adoption, immigration and naturalization, or examinations or treatment ordered by a court or an employer; premarital blood testing;

41) **Infertility/Reproductive Services** - All diagnostic studies, non-diagnostic services, and certain surgical procedures that are related to diagnosing and/or treating Infertility. Also excluded are expenses incurred for the promotion of conception including, but not limited to, artificial insemination, intracytoplasmic sperm injection ("ICSI"), in vitro or in vivo fertilization, gamete intrafallopian transfer ("GIFT") procedures, zygote intrafallopian transfer ("ZIFT") procedures, embryo transport, egg harvesting (collection, storage, preparation), reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis (for example, determining sex) , other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered under the terms of the Policy; No legal obligation to pay - Services are excluded for Injuries and Illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health services and supplies furnished under or as part of a study, grant, or research program;

42) **Maternity Services** – Expenses incurred for any condition of or related to pregnancy, except complications arising from and unless specifically covered in the Schedule of Benefits. Also excluded are expenses associated with selective reduction during pregnancy.

43) **Maintenance Therapy** – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;

44) **Male Gynecomastia –** Those services and associated expenses for treatment of male gynecomastia.

45) **Massage Therapy – Those services and associated expenses related to massage therapy;**

46) **Medical complications** arising directly or indirectly from a non-Covered Service;

47) **Mental Health Services -** the diagnosis and treatment of all biologically based Mental Illnesses and psychiatric conditions, unless Covered by an attached Mental Health Substance Abuse Rider;

48) **Military Health Services** - Those services for treatment of military service-related disabilities when the Insured is legally entitled to other Coverage and for which facilities are reasonably available to the Insured; or those services for any Insured who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;

49) **Miscellaneous Service Charges** - Telephone consultations, document processing or copying fees, mailing costs, charges for completion of forms, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), any late payment charge, interest charges or other non-medical charges;

50) **Non-Prescription Drugs and Medications** - Over-the-counter ("OTC") drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

51) **Nutritional-based Therapy** - Nutritional-based therapies except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

52) **Newborn** home delivery and also the cost of child birth classes;

53) **Obesity Services** - Those services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature

54) **Occupational Injury** - Those services and associated expenses related to the treatment of an occupational Injury or Illness for which the Insured is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services under this Policy;

55) **Oral Surgery Supplies** - required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;

56) **Orthodontia** and related services;

57) **Orthotic Appliances, Repairs or Replacement** - The replacement costs for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated; also excluded are cranial (head) remodeling band for the treatment of postitional non-synostotic plagiocephaly; and other protective head gear;

56) **Over-the-counter supplies** such as ACE wraps, elastic supports, finger splints, Orthotics, and braces; also OTC products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

59) **Personal comfort and convenience** items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

60) **Prescription Drugs and Medications** - Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider.

61) **Private Duty Nursing** - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;

62) **Prosthetic Devices Repairs or Replacement** - The replacement costs for any otherwise Covered device, including replacement for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured;

62) **Private inpatient room**, unless Medically Necessary or if a Semi-private room is unavailable;

64) **Reduction or Augmentation Mammoplasty** - Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer;

65) **Reversal of Sterilization Services** - Those services and associated expenses related to reversal of voluntary sterilization;

66) **Sex Transformation Services** - Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;

67) **Sexual Dysfunction** - Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;

68) **Sleep Studies – Sleep studies provided within the home;**

69) **Smoking Cessation** - Those services and supplies for smoking cessation programs and treatment of nicotine addiction;

70) **Speech therapy** or voice training when prescribed for stuttering or hoarseness;

71) **Sports Related Services** - Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces and orthotics;

72) **Substance Abuse** diagnosis and treatment, unless Covered by an attached Mental Illness Substance Abuse Rider;

73) **Surrogate motherhood** services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of the Insured acting as a surrogate mother;

75) **Transplant Organ Removal** - Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not Covered under the Policy unless the recipient is the Insured and the donor's medical Coverage excludes reimbursement for organ harvesting;

76) **Transplant services**, screening tests, and any related conditions or complications related to organ donation when the Insured is donating organ or tissue to a person not Covered under the Policy;

77) **Transplant Services** and associated expenses involving temporary or permanent mechanical or animal organs;

78) **Travel Expenses** - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section;

79) **Treatment for disorders** relating to learning, motor skills and communication;

80) **Vision Aids, Associated Services** - Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;

81) **Vocational therapy**;

82) Health services resulting from **war or an act of war** when the Insured is outside of the continental United States; and

83) **Work hardening programs**.

Coordination of Benefits

This section describes how Benefits under this Policy will be coordinated with those of any other plan that provides Benefits to You.

The order of Benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the Benefits it pays, so that payment from all plans do not exceed 100% of the Plan's Allowable Expenses.

Definitions

A **Plan**, or "other plan" is any of those which provides Benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. In addition, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"Allowable Expense" means a health care service or expense including Deductibles and Copayments, that is Covered, at least in part by any of the Plans covering You or Your Covered Dependent. When a Plan provides benefits in the form of service (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not Covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are not the Plan's Allowable Expenses:

- If a Insured is Confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is otherwise a Covered benefit) is not an Allowable Expense.
- If a Insured is Covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If a Insured is Covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.
- The amount a benefit is reduced because a Insured does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

"Claim Determination Period" means a Benefit Year. However, it does not include any part of a year during which an Insured has no Coverage under the Plan, or before the date this COB provision or a similar provision takes effect.

"Closed Panel Plan" is a Plan that provides health benefits to Covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

"Joint Custody" If the specific terms of a court decree state that the parents shall share joint custody without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined below.

Order of Benefit Determination Rules

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

- The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
- A Plan that does not contain a COB provision that is consistent with this provision is always Primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical Coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type Coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.
- The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.
  - √ Non-Dependent or Dependent. The Plan that covers the Insured other than as a Dependent, for example as an employee, Insured, Subscriber or retiree is Primary and the Plan that covers the Insured as a Dependent is Secondary. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Insured as a Dependent; and Primary to the Plan covering the Insured as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Insured as an employee, Insured, Subscriber or retiree is Secondary and the other Plan is Primary.
  - √ Child Covered Under More Than One Plan. The order of benefits when a child is Covered by more than one Plan is:
    - The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
      - √ The parents are married;
      - √ The parents are not separated (whether or not they ever have been married); or
    - If both parents have the same birthday, the Plan that Covered either of the parents longer is Primary.
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care Coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
  - √ The Plan of the Custodial Parent;
  - √ The Plan of the spouse of the Custodial Parent;
  - √ The Plan of the non-custodial parent; and then
  - √ The Plan of the spouse of the non-custodial parent.

√ Active or inactive employee. The Plan that covers a Insured as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Insured is a dependent of a person Covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

√ Continuation coverage. If a Insured whose coverage is provided under a right of continuation provided by federal or state law also is Covered under another Plan, the Plan covering the Insured as an employee, Insured, Subscriber or retiree (or as that Insured's dependent) is Primary, and the continuation Coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

√ Longer or shorter length of coverage. The Plan that Covered the Insured as an employee, Insured, subscriber or retiree longer is Primary.

√ If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, the Plan will not pay more than the Plan would have paid had the Plan been Primary.

Effect On The Benefits of the Plan

- The Benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- The Benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision (whether or not claim is made) exceeds those Allowable Expenses in a claim determination period. In that case, the Benefits of this plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses. When the Benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

- Provide the Plan with information about other coverage and promptly notify the Plan of any coverage changes;
- Give the Plan the right to obtain information as needed from others to coordinate benefits;
- Return any excess amounts paid to you to the Plan if the Plan or Your Provider provides a credit or payment and later finds that the other Coverage should have been primary.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Agreement. If it does, the Plan may pay the amount to the organization that made the payment. The amount will then be treated as though it was a benefit paid under the Agreement. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payment made by the Plan, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the terms of the Agreement, the Plan may recover the excess payments from one (1) or more of:

- The persons it has paid; or
- For whom it has paid; or
- Insurance companies; or
- Other organizations.

Right of Reimbursement

In consideration of the coverage provided by this Policy, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - √ Providing any relevant information requested by Us,
  - √ Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - √ Responding to requests for information about any accident or injuries,
  - √ Making court appearances, and
  - √ Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;

- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

The Insured may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, the Insured or Authorized Representative may call or write the Plan to file a complaint or an appeal. We will consider all the facts and handle all complaints and appeals promptly and fairly.

Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this Policy.

Complaints

A complaint is an expression of dissatisfaction that may be resolved on an informal basis. Complaints may be expressed by telephone or in person and are handled by Our Customer Service Department. The Customer Service Department may involve one or more staff members of the Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.

Written Complaints will be acknowledged in writing by Plan within 5 working days after receipt of the Complaint. The Plan will conduct an investigation within 20 working days after receipt of the respective Complaint, unless the investigation cannot be completed within this time. If the investigation cannot be completed within the 20-day timeframe, the Insured will be notified in writing by the 20th working day of the specific reasons for the delay, and the investigation will be completed within 30 working days thereafter. The Insured will be notified of the resolution within five (5) working days after the investigation of the respective Complaint is completed. Within fifteen (15) working days after the investigation of the respective Complaint is completed, the person, if other than the Insured, who submitted the Complaint will be notified.

The address and telephone numbers for Complaints are:

Coventry Health & Life Insurance Company
P.O. Box 7109
London, KY 40742
Telephone: (800) 969-3343

Appeals

If the issue in dispute relates to an Adverse Benefit Determination and the Insured and/or the Authorized Representative are dissatisfied with resolution of the complaint or does not wish to first file a Complaint, he or she may file an Appeal. The Appeals must be made within 180 days of the Adverse Benefit Determination.

The address for the Appeals Department is:

Coventry Health & Life Insurance Company
Attn: Appeals Department
8320 Ward Parkway
Kansas City, MO 64114

You may ask Us to appoint a staff member to assist with the Appeal at any time during the process.

One level of internal Appeal is provided if You, or your Authorized Representative, disagree with an Adverse Benefit Determination. The Insured or Authorized Representative may file an Appeal by sending Us a letter describing the reason for the Appeal. For Appeals based in whole or in part on medical judgment, the Appeal Committee will include a Medical Director and/or a Physician designee who have no prior involvement in the case and who are not subordinates of the individual who rendered the Adverse Benefit Determination. If the Medical Director and/or Physician designee are not in the same or similar specialty of the case under review, the Committee will also consult a health care professional who has training and experience in that

field of medicine.

- § Appeals are concluded as follows:

  - √ Urgent Care Appeals –Urgent Care Appeals will be completed within 72 hours after receipt of the Appeal request. We will notify the Insured and/or Authorized Representatives verbally and provide a follow-up written notice within 24 hours after receipt of the Appeal request.
  - √ Pre-service Appeals – Requests for Pre-service Appeals will be acknowledged by letter within 5 working days of receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 15 calendar days of receipt of the Appeal request; however, with the Insured's permission, We may delay the resolution of the Appeal for 30 calendar days if We have not received adequate information.
  - √ Post-service Appeals – Requests for Post-service Appeals will be acknowledged by letter within 5 working days of receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 20 working days from the date of the request for a Appeal; however, with the Insured's permission, We may delay the resolution of the Appeal for 30 calendar days if We have not received adequate information.

The Insured will be notified of the resolution within five (5) working days after the investigation of the respective Appeal is completed. Within fifteen (15) working days after the investigation of the respective Appeal is completed, the person, if other than the Insured, who submitted the Appeal will be notified. Our written notification to the Insured or Authorized Representative will provide the reason for the decision. Our notice will give the Insured or Authorized Representative instructions on any additional Appeal Rights available.

Contact Information

You may contact your respective the Insurance Department at anytime by mail or telephone: Arkansas Department of Insurance, 1200 West Third Street, Little Rock, AR 72201, (501) 371 2600 or (800) 282-9134, and fax at (501) 371-2618, or via email at Insurance.Consumers@arkansas.gov.

General Provisions

Applicability

The provisions of this Policy shall apply to the Insured and all benefits and privileges shall be available to You .

Governing Law

This Policy is delivered and governed by the laws of the State of Arkansas for Arkansas residents.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of five (5) years after the time written proof of loss is required to be furnished.

You are encouraged to exhaust the Policy's Complaint and Grievance Procedures prior to pursuing legal action, (in a court or other government tribunal) as this may be the most expeditious and cost-effective method of resolving Your concerns.

Time Limit On Certain Defenses

After two years from the date of issue of this Policy no misstatements, except fraudulent misstatement, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

No claim for loss incurred or disability commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from Coverage by name or specific description effective on the date of loss has existed prior to the effective date of Coverage of this Policy.

Nontransferable

No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by the Plan under this Policy. Such right to health care service Coverage or other benefits is not transferable.

Relationship Among Parties Affected by this Policy

The relationship between the Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Plan, nor is the Plan or any employee of the Plan an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

You are not an agent or representative of the Plan, and shall not be liable for any acts or omissions of the Plan for the performance of services under this Policy.

Contractual Relationships

The Plan agrees to provide Coverage for services to the Insured, subject to the terms, conditions, exclusions and limitations of the Policy. This Policy is issued on the basis of the Insured's enrollment in the Plan, and the payment and the Plan's acceptance of the required Premium. The Plan has the right to increase Premium rates, provided the Insured is given thirty-one (31) days advance written notice.

Reservations and Alternatives

The Plan reserves the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein. The identity of the service providers and the nature of the services provided may be changed from time to time and without prior notice to or approval by the Insured. You must cooperate with those persons or entities in the performance of their responsibilities.

Severability

In the event that any provision of this Policy is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Policy, which shall continue in full force and effect in accordance with its remaining terms.

Entire Contract

No change in this Policy shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Policy and/or by Amendment to this Policy. Such Amendments will be incorporated into this Policy. Amendments to the Policy are effective upon thirty-one (31) days written notice to the Insured. No change will be made to the Policy unless made by an Amendment or a Rider that is issued by the Plan. No agent or representative has authority to change the Policy or to waive any of its provisions.

This Policy, including all matters incorporated, contains the entire agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained herein. This Policy, including the application agreement, and all endorsements, exhibits, addenda, or amendments, if any, supersedes all prior communications, representations, or agreements, either verbal or written, between the parties.

Waiver

The failure of the Plan or You to enforce any provision of this Policy shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Policy shall not be deemed or construed to be a waiver of such default.

Records

The Insured shall furnish the Plan with all medical information and proofs of previous Coverage that the Plan may reasonably require with regard to any matters pertaining to this Policy in the event the Plan is unable to obtain this information directly from the Provider or previous insurer.

By accepting Coverage under the Policy, the Insured, who has signed the application, authorizes and directs any person or institution that has provided services to the Insured, to furnish the Plan or any of the Plan’s designees at any reasonable time, upon its request, relevant information and records or copies of records relating to the services provided to the Insured. The Plan agrees that such information and records will be considered confidential. The Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning services which are necessary to implement and administer the terms of the Policy or for appropriate medical review or quality assessment.

Examination of the Insured

In the event of a question or dispute concerning Coverage for services, the Plan may reasonably require that a Participating Provider acceptable to the Plan examine the Insured at the Plan’s expense.

Payment of Claims

Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

Clerical Error

Clerical error shall not deprive any individual of Coverage under the Policy or create a right to additional benefits.

Workers' Compensation

The Coverage provided under this Policy does not substitute for and does not affect any requirements for Coverage by any Workers' Compensation Insurance law, occupational disease law or similar legislation.

Misrepresentation

Coventry Health Care of Kansas, Inc. will not provide coverage for any Insured who has knowingly concealed or misrepresented any material fact or circumstance relating to this Policy in connection with the presentation or settlement of a claim.

Conformity with Statutes

Any provision of this Policy which, on its Effective Date, is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes and regulations.

Non-Discrimination

In compliance with state and federal law, the Plan shall not discriminate on the basis of age, color, disability, gender, marital status, national origin, religion, sexual preference, or public assistance status.

Cancellation By Insured

The Insured may cancel this Policy at any time by written notice delivered or mailed to the Plan, effective upon receipt of such notice or on such late date as may be specified in such notice. In the event of cancellation or death of the Insured, the Plan will promptly return the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Important Numbers & Addresses

Customer Service / Claims	**Pre-Certification**
Coventry Health & Life Insurance Company Customer Service PO Box 7109 London, KY 40742 (800) 969-3343 (866) 285-1864 TDD http://www.chckansas.com/	Coventry Health & Life Insurance Company 8320 Ward Parkway Kansas City, MO 64114 (877) 837-8914
Appeals and Grievance	**Arkansas Department of Insurance**
Coventry Health & Life Insurance Company Attn: Appeals Department 8320 Ward Parkway Kansas City, MO 64114	1200 West Third St Little Rock, AR 72201 (800) 282-9134 Insurance.Consumers@arkansas.gov

COVENTRY
Health and Life Insurance Company

ACTUARIAL MEMORANDUM
COVENTRY HEALTH AND LIFE INSURANCE COMPANY
ARKANSAS SERVICE AREAS
Individual PPO Filing

1. Scope and Purpose:

I, James W. Brown, am a Member of the American Academy of Actuaries and an Associate of the Society of Actuaries. Coventry Health and Life Insurance Company (CHL) is filing rates for prospective business within its Arkansas service areas sold to individuals. The rates in this filing are for new individual plans, and the description of coverage is enclosed. It is not appropriate to use this actuarial rate certification for any other purpose.

2. Proprietary:

CHL considers this submission to contain proprietary information. We respectfully request that it be kept confidential to the maximum extent permitted under law.

3. Description of Benefits:

CHL will offer PPO benefit plans to individuals. This offering utilizes a variety of copay, coinsurance, deductible, and out-of-pocket options. Benefit options for the new plans are described in the New Plan Summary enclosed in Attachment 1.

4. Renewability:

The individual policy is guaranteed renewable at the option of the policyholder, except for reasons as described in the policy. Premiums listed are on a monthly basis.

5. Applicability:

The rating factors are appropriate for contracts with January 1, 2011 - March 30, 2011 effective dates. The rates included apply to new business and renewal business.

6. Morbidity:

Medical cost assumptions used to develop the rates are based on analysis of Mercy Health Plan (recently acquired by Coventry Health Care) experience, provider network performance experience, assumed utilization patterns and anticipated changes in utilization trends for the projection period.

6705 Rockledge Drive • Suite 900 • Bethesda, MD 20817-1850
301.581.0600 • 800.843.7421

7. Mortality:

Mortality was not used in developing the rates.

8. Persistency:

Persistency is anticipated to be 70% in all policy years.

9. Expenses:

Expenses are priced for using the PPACA minimum loss ratio threshold of 80%. As the minimum loss ratio threshold is a one-sided test, the American Academy of Actuaries (AAA) prepared a credibility adjustment intended to provide for statistical fluctuations in results. Based on our anticipated enrollment of 2,000 lives, the adjustment provided in the AAA study is 12%. As such, this filing assumes a target loss ratio of 68%. Expenses will be managed internally around this level, including broker commissions.

10. Marketing Method:

CHL products are sold to individuals through CHL representatives and independent, licensed brokers and agents.

11. Underwriting:

Medical underwriting guidelines are applied consistently and fairly on all applicants.

12. Premium Classes:

CHL will offer one class of business.

13. Issue Age Ranges:

CHL will issue and renew until Medicare eligible due to age, except where limited by law.

14. Premium Modalization Rules:

Not applicable.

15. Active Life Reserves:

Active life reserves will be held under the guidance set forth in Arkansas law and regulation, NAIC guidelines, and Actuarial Standards of Practice.

COVENTRY
Health and Life Insurance Company

16. Trend Assumptions:

The maximum trend rate that will be applied is: 10%. Lower trend rates may apply based on emerging experience and expected future claims levels. This trend will only be applied upon renewal.

17. Rating Methodology

CHL will utilize age and gender specific rates.

18. Anticipated Loss Ratios:

The anticipated loss ratio for this block of business is 68.0%, as described in the expense section.

19. Past Experience and Lifetime Loss Ratio:

Since this is a new product and rate filing, there is no prior experience.

20. History of Rate Adjustments:

Since this is a new product and rate filing, there are no prior rate adjustments.

21. Numbers of Policyholders:

Since this is a new product and rate filing, there are no prior current members in the Arkansas service areas.

22. Proposed Effective Date:

The new rating factors are appropriate for contracts with January 1, 2011 effective dates.

23. Rates:

Please see attached rate pages (Attachment 2). Premium rates for individuals will vary by benefit plan design, underwriting, age/gender, and area. The development of projected base rates for 2011 was based on the experience of the recently acquired Mercy Health Plans experience in Arkansas, as shown in Attachment 3. We consider Attachment 3 proprietary. We respectfully request that it be kept confidential to the maximum extent permitted under law.

COVENTRY
Health and Life Insurance Company

24. Actuarial Certification:

I, James W. Brown, have reviewed the premium and claim experience used to develop the proposed rates for the individual products in Arkansas. I have relied on analysis provided by staff of Mercy Health Plan, and have reviewed the information for reasonableness.

I hereby certify that to the best of my knowledge and ability, the following are true with respect to this filing:

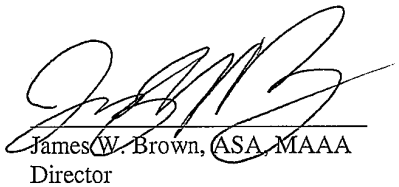
a. The assumptions present the actuary's best judgment as to the expected value for each assumption
and are consistent with the issuer's business plan at the time of the filing.

b. The filing is in compliance with applicable laws and regulations in the state.

c. The loss ratios comply with the regulatory loss ratio requirements.

d. The rates are adequate and reasonable in relationship to the benefits provided, and are not excessive or unfairly discriminatory between policyholders.

e. The rates comply with accepted actuarial practices.



10/8/2010

James W. Brown, ASA, MAAA
Director
Coventry Health Care, Inc.
1100 Circle 75 Parkway
Atlanta, GA 30339
Phone: (678) 202-2145
E-Mail: jwbrown@cvty.com

Date

Coventry Health and Life Insurance Company
Arkansas Individual Plans
Age and Area Factors
January 1, 2011

Exhibit 2

Age Factors

Age Band	Male	Female
6 months - 1 yr	1.244	1.244
1-4	1.244	1.244
5-18	0.602	0.602
19-24	0.564	0.770
25-29	0.640	0.923
30-34	0.813	1.175
35-39	1.000	1.395
40-44	1.277	1.547
45-49	1.627	1.810
50-54	2.187	2.181
55-59	2.847	2.593
60-64	3.757	3.096
65+	3.757	3.096

Smoker Load:	20%
TMJ Rider Rate:	$2.20
MH/SA Rider Rate:	$8.65
Hearing Aid Rider Rate:	$1.90
Maximum Annual Trend:	10%

Area Factors

County	Region	Factor
Benton	NW Arkansas	0.90
Carroll	NW Arkansas	0.90
Madison	NW Arkansas	0.90
Washingt	NW Arkansas	0.90
Franklin	Fort Smith	1.00
Logan	Fort Smith	1.00
Scott	Fort Smith	1.00
Sebastian	Fort Smith	1.00
Clark	Hot Springs	1.10
Garland	Hot Springs	1.10
Hot Sprin	Hot Springs	1.10
Montgom	Hot Springs	1.10
Pike	Hot Springs	1.10
Baxter	Springfield Border	0.92
Boone	Springfield Border	0.92
Fulton	Springfield Border	0.92
Marion	Springfield Border	0.92
Faulkner	Little Rock	1.05
Lonoke	Little Rock	1.05
Pulaski	Little Rock	1.05
Saline	Little Rock	1.05
White	Little Rock	1.05
All Other		1.35

REVISED October 1, 2010

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Attachment 3 - Premium Development/Projection
PROPRIETY and CONFIDENTIAL

ARK Mercy One Claims Experience from 7/1/2008 to 3/31/2009
Trended forward to July 1, 2011
Member Month Exposure: 36,606
Average Geographic Factor: 1.00
Average duration was 5.8 months, so utililzation adjusted by 26.2% to reflect average duration
Trend assumed at 10%

Net Paid Dollars	Total
Inpatient	$31.07
Outpatient	$50.70
Physician Services	$60.81
Pharmacy	$18.48
Other	$2.15
Sub Total	$163.20
Back out MH/SA (Mandated Offer Rider):	$1.34
Total Med Expense:	$161.86
Back out Average Age-Gender Factor in Experience:	1.288
Back out average UW load (estimated):	1.163
Male, age 37 Net Paid Claims PMPM:	$108.06
PPACA Adjustments	
Removal of Lifetime Limits:	0.25%
Removal of Annual DME Limit:	0.50%
$0 Preventive Cost Sharing:	2.00%
TOTAL PPACA IMPACT:	2.75%
ADJ Male, age 37 Net Paid Claims PMPM:	$111.03
Minimum Loss Ratio Target:	80%
American Academy of Actuaries 80% C.I. Credibility Adjustment	12%
* Assumes 2,000 average members	
Adjusted Target Loss Ratio:	68%
Projected Premium:	$162.76

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan A	217.98	217.98	239.78	239.78	217.98	217.98	196.18	196.18	200.54	200.54	294.27	294.27
1 - 4		217.98	217.98	239.78	239.78	217.98	217.98	196.18	196.18	200.54	200.54	294.27	294.27
5 - 18		105.45	105.45	116.00	116.00	105.45	105.45	94.91	94.91	97.02	97.02	142.36	142.36
19 - 24		98.79	134.92	108.67	148.41	98.79	134.92	88.91	121.43	90.89	124.13	133.37	182.14
25 - 29		112.05	161.73	123.26	177.90	112.05	161.73	100.85	145.55	103.09	148.79	151.27	218.33
30 - 34		142.40	205.88	156.64	226.47	142.40	205.88	128.16	185.29	131.01	189.41	192.25	277.94
35 - 39		175.22	244.43	192.74	268.87	175.22	244.43	157.70	219.99	161.20	224.88	236.55	329.98
40 - 44		223.68	271.06	246.05	298.17	223.68	271.06	201.31	243.96	205.79	249.38	301.97	365.94
45 - 49		285.16	317.15	313.67	348.86	285.16	317.15	256.64	285.43	262.34	291.78	384.96	428.15
50 - 54		383.29	382.15	421.61	420.37	383.29	382.15	344.96	343.94	352.62	351.58	517.43	515.91
55 - 59		498.85	454.34	548.74	499.78	498.85	454.34	448.97	408.91	458.94	418.00	673.45	613.36
60 - 64		658.32	542.48	724.15	596.73	658.32	542.48	592.49	488.23	605.65	499.08	888.73	732.35

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan B	183.39	183.39	201.73	201.73	183.39	183.39	165.05	165.05	168.72	168.72	247.58	247.58
1 - 4		183.39	183.39	201.73	201.73	183.39	183.39	165.05	165.05	168.72	168.72	247.58	247.58
5 - 18		88.72	88.72	97.59	97.59	88.72	88.72	79.85	79.85	81.62	81.62	119.77	119.77
19 - 24		83.11	113.51	91.43	124.86	83.11	113.51	74.80	102.16	76.46	104.43	112.20	153.24
25 - 29		94.27	136.06	103.70	149.67	94.27	136.06	84.85	122.46	86.73	125.18	127.27	183.69
30 - 34		119.81	173.21	131.79	190.53	119.81	173.21	107.83	155.89	110.22	159.36	161.74	233.84
35 - 39		147.42	205.64	162.16	226.21	147.42	205.64	132.67	185.08	135.62	189.19	199.01	277.62
40 - 44		188.19	228.05	207.01	250.86	188.19	228.05	169.37	205.25	173.13	209.81	254.05	307.87
45 - 49		239.91	266.82	263.90	293.50	239.91	266.82	215.92	240.14	220.71	245.48	323.87	360.21
50 - 54		322.46	321.51	354.71	353.66	322.46	321.51	290.22	289.36	296.67	295.79	435.33	434.04
55 - 59		419.69	382.25	461.66	420.47	419.69	382.25	377.72	344.02	386.12	351.67	566.59	516.03
60 - 64		553.85	456.40	609.24	502.04	553.85	456.40	498.47	410.76	509.55	419.89	747.70	616.14

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan C	154.88	154.88	170.37	170.37	154.88	154.88	139.39	139.39	142.49	142.49	209.09	209.09
1 - 4		154.88	154.88	170.37	170.37	154.88	154.88	139.39	139.39	142.49	142.49	209.09	209.09
5 - 18		74.93	74.93	82.42	82.42	74.93	74.93	67.43	67.43	68.93	68.93	101.15	101.15
19 - 24		70.19	95.86	77.21	105.45	70.19	95.86	63.17	86.28	64.58	88.20	94.76	129.42
25 - 29		79.62	114.91	87.58	126.40	79.62	114.91	71.66	103.42	73.25	105.72	107.48	155.13
30 - 34		101.18	146.29	111.30	160.92	101.18	146.29	91.06	131.66	93.09	134.58	136.60	197.49
35 - 39		124.50	173.68	136.95	191.04	124.50	173.68	112.05	156.31	114.54	159.78	168.07	234.46
40 - 44		158.93	192.60	174.83	211.86	158.93	192.60	143.04	173.34	146.22	177.19	214.56	260.01
45 - 49		202.61	225.34	222.87	247.88	202.61	225.34	182.35	202.81	186.40	207.32	273.53	304.21
50 - 54		272.34	271.53	299.57	298.69	272.34	271.53	245.10	244.38	250.55	249.81	367.65	366.57
55 - 59		354.45	322.83	389.90	355.11	354.45	322.83	319.01	290.54	326.10	297.00	478.51	435.82
60 - 64		467.76	385.45	514.53	423.99	467.76	385.45	420.98	346.90	430.34	354.61	631.47	520.36

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan D	202.48	202.48	222.73	222.73	202.48	202.48	182.23	182.23	186.28	186.28	273.35	273.35
1 - 4		202.48	202.48	222.73	222.73	202.48	202.48	182.23	182.23	186.28	186.28	273.35	273.35
5 - 18		97.95	97.95	107.75	107.75	97.95	97.95	88.16	88.16	90.12	90.12	132.24	132.24
19 - 24		91.77	125.33	100.94	137.86	91.77	125.33	82.59	112.79	84.43	115.30	123.88	169.19
25 - 29		104.09	150.23	114.50	165.25	104.09	150.23	93.68	135.21	95.76	138.21	140.52	202.81
30 - 34		132.28	191.24	145.51	210.37	132.28	191.24	119.05	172.12	121.70	175.95	178.58	258.18
35 - 39		162.76	227.05	179.04	249.76	162.76	227.05	146.49	204.35	149.74	208.89	219.73	306.52
40 - 44		207.78	251.79	228.56	276.97	207.78	251.79	187.00	226.61	191.16	231.65	280.50	339.92
45 - 49		264.88	294.60	291.37	324.06	264.88	294.60	238.39	265.14	243.69	271.03	357.59	397.71
50 - 54		356.03	354.98	391.64	390.48	356.03	354.98	320.43	319.48	327.55	326.58	480.65	479.23
55 - 59		463.39	422.04	509.72	464.24	463.39	422.04	417.05	379.84	426.31	388.28	625.57	569.76
60 - 64		611.51	503.91	672.66	554.30	611.51	503.91	550.36	453.52	562.59	463.60	825.54	680.28

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan E	189.85	189.85	208.84	208.84	189.85	189.85	170.87	170.87	174.66	174.66	256.30	256.30
1 - 4		189.85	189.85	208.84	208.84	189.85	189.85	170.87	170.87	174.66	174.66	256.30	256.30
5 - 18		91.84	91.84	101.03	101.03	91.84	91.84	82.66	82.66	84.50	84.50	123.99	123.99
19 - 24		86.04	117.51	94.65	129.26	86.04	117.51	77.44	105.76	79.16	108.11	116.16	158.64
25 - 29		97.60	140.86	107.35	154.94	97.60	140.86	87.84	126.77	89.79	129.59	131.75	190.16
30 - 34		124.03	179.32	136.43	197.25	124.03	179.32	111.63	161.38	114.11	164.97	167.44	242.08
35 - 39		152.61	212.89	167.87	234.18	152.61	212.89	137.35	191.60	140.40	195.86	206.02	287.40
40 - 44		194.82	236.09	214.30	259.69	194.82	236.09	175.34	212.48	179.23	217.20	263.00	318.72
45 - 49		248.36	276.22	273.20	303.84	248.36	276.22	223.52	248.60	228.49	254.12	335.29	372.90
50 - 54		333.83	332.84	367.21	366.12	333.83	332.84	300.44	299.56	307.12	306.21	450.67	449.33
55 - 59		434.48	395.72	477.93	435.29	434.48	395.72	391.03	356.14	399.72	364.06	586.55	534.22
60 - 64		573.37	472.48	630.71	519.73	573.37	472.48	516.03	425.23	527.50	434.68	774.05	637.84

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan F	172.08	172.08	189.29	189.29	172.08	172.08	154.87	154.87	158.32	158.32	232.31	232.31
1 - 4		172.08	172.08	189.29	189.29	172.08	172.08	154.87	154.87	158.32	158.32	232.31	232.31
5 - 18		83.25	83.25	91.57	91.57	83.25	83.25	74.92	74.92	76.59	76.59	112.38	112.38
19 - 24		77.99	106.51	85.79	117.16	77.99	106.51	70.19	95.86	71.75	97.99	105.29	143.79
25 - 29		88.46	127.67	97.31	140.44	88.46	127.67	79.61	114.91	81.38	117.46	119.42	172.36
30 - 34		112.42	162.53	123.66	178.79	112.42	162.53	101.18	146.28	103.43	149.53	151.77	219.42
35 - 39		138.33	192.96	152.16	212.26	138.33	192.96	124.49	173.67	127.26	177.53	186.74	260.50
40 - 44		176.58	213.99	194.24	235.39	176.58	213.99	158.92	192.59	162.46	196.87	238.39	288.89
45 - 49		225.11	250.37	247.62	275.41	225.11	250.37	202.60	225.33	207.10	230.34	303.90	338.00
50 - 54		302.58	301.69	332.84	331.86	302.58	301.69	272.32	271.52	278.37	277.55	408.48	407.28
55 - 59		393.81	358.68	433.20	394.54	393.81	358.68	354.43	322.81	362.31	329.98	531.65	484.21
60 - 64		519.70	428.25	571.67	471.08	519.70	428.25	467.73	385.43	478.13	393.99	701.60	578.14

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan G	140.98	140.98	155.08	155.08	140.98	140.98	126.88	126.88	129.70	129.70	190.32	190.32
1 - 4		140.98	140.98	155.08	155.08	140.98	140.98	126.88	126.88	129.70	129.70	190.32	190.32
5 - 18		68.20	68.20	75.02	75.02	68.20	68.20	61.38	61.38	62.74	62.74	92.07	92.07
19 - 24		63.89	87.26	70.28	95.98	63.89	87.26	57.50	78.53	58.78	80.28	86.25	117.80
25 - 29		72.47	104.60	79.72	115.06	72.47	104.60	65.22	94.14	66.67	96.23	97.84	141.20
30 - 34		92.10	133.15	101.31	146.47	92.10	133.15	82.89	119.84	84.73	122.50	124.33	179.76
35 - 39		113.32	158.08	124.65	173.89	113.32	158.08	101.99	142.28	104.26	145.44	152.98	213.41
40 - 44		144.66	175.31	159.13	192.84	144.66	175.31	130.20	157.78	133.09	161.28	195.30	236.67
45 - 49		184.42	205.11	202.87	225.62	184.42	205.11	165.98	184.60	169.67	188.70	248.97	276.90
50 - 54		247.89	247.16	272.68	271.87	247.89	247.16	223.10	222.44	228.06	227.38	334.65	333.66
55 - 59		322.63	293.84	354.89	323.23	322.63	293.84	290.37	264.46	296.82	270.34	435.55	396.69
60 - 64		425.76	350.85	468.34	385.93	425.76	350.85	383.19	315.76	391.70	322.78	574.78	473.64

Coventry Health and Life Insurance Company
Arkansas Individual - New Plans 2011
Attachment 1

	PLAN A		PLAN B		PLAN C		PLAN D		PLAN E		PLAN F		PLAN G	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Deductible	$1,000	$2,000	$2,500	$5,000	$5,000	$10,000	$1,000	$2,000	$1,500	$3,000	$2,500	$5,000	$5,000	$10,000
Coinsurance	80%	60%	80%	60%	80%	60%	80%	60%	80%	60%	80%	60%	80%	60%
Out of Pocket	$3,500	$7,000	$5,000	$10,000	$7,500	$15,000	$4,500	$9,000	$5,000	$10,000	$6,000	$12,000	$8,500	$17,000
Hospital	100%	75%	100%	75%	100%	75%	80%	60%	80%	60%	80%	60%	80%	60%
PCP Office Visit	$30	75%	$30	75%	$30	75%	$30	60%	$30	60%	$30	60%	$30	60%
Specialist	$60	75%	$60	75%	$60	75%	$60	60%	$60	60%	$60	60%	$60	60%
ER	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200
Urgent Care	$75	$200	$75	$200	$75	$200	$75	$200	$75	$200	$75	$200	$75	$200
Preventive Health	100%	75%	100%	75%	100%	75%	100%	75%	100%	75%	100%	75%	100%	75%
Ambulance	100%	100%	100%	100%	100%	100%	80%	80%	80%	80%	80%	80%	80%	80%
Chiropractor	Visit Limits		Visit Limits		Visit Limits		Visit Limits		Visit Limits		Visit Limits		Visit Limits	
Vision	$60		$60		$60		$60		$60		$60		$60	
Mental Health/Substance Abuse	Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above	
Hearing Aids/Service	Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above	
TMJ	Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above	
RX Tier 1	$10	50%	$10	50%	$10	50%	$10	50%	$10	50%	$10	50%	$10	50%
RX Tier 2	$35	50%	$35	50%	$35	50%	$35	50%	$35	50%	$35	50%	$35	50%
RX Tier 3	$70	50%	$70	50%	$70	50%	$70	50%	$70	50%	$70	50%	$70	50%
RX Tier 4	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%

* Maternity is not covered under these plans
** All essential benefits are unlimited from a dollar perspective, as required under PPACA

COVENTRY
Health and Life Insurance Company

ACTUARIAL MEMORANDUM
COVENTRY HEALTH AND LIFE INSURANCE COMPANY
ARKANSAS SERVICE AREAS
Individual PPO Filing

1. Scope and Purpose:

I, James W. Brown, am a Member of the American Academy of Actuaries and an Associate of the Society of Actuaries. Coventry Health and Life Insurance Company (CHL) is filing rates for prospective business within its Arkansas service areas sold to individuals. The rates in this filing are for new individual plans, and the description of coverage is enclosed. It is not appropriate to use this actuarial rate certification for any other purpose.

2. Proprietary:

CHL considers this submission to contain proprietary information. We respectfully request that it be kept confidential to the maximum extent permitted under law.

3. Description of Benefits:

CHL will offer PPO benefit plans to individuals. This offering utilizes a variety of copay, coinsurance, deductible, and out-of-pocket options. Benefit options for the new plans are described in the New Plan Summary enclosed in Attachment 1.

4. Renewability:

The individual policy is guaranteed renewable at the option of the policyholder, except for reasons as described in the policy. Premiums listed are on a monthly basis.

5. Applicability:

The rating factors are appropriate for contracts with January 1, 2011 - March 30, 2011 effective dates. The rates included apply to new business and renewal business.

6. Morbidity:

Medical cost assumptions used to develop the rates are based on analysis of Mercy Health Plan (recently acquired by Coventry Health Care) experience, provider network performance experience, assumed utilization patterns and anticipated changes in utilization trends for the projection period.

6705 Rockledge Drive • Suite 900 • Bethesda, MD 20817-1850
301.581.0600 • 800.843.7421

COVENTRY
Health and Life Insurance Company

7. Mortality:

Mortality was not used in developing the rates.

8. Persistency:

Persistency is anticipated to be 70% in all policy years.

9. Expenses:

Expenses are priced for using the PPACA minimum loss ratio threshold of 80%. As the minimum loss ratio threshold is a one-sided test, the American Academy of Actuaries (AAA) prepared a credibility adjustment intended to provide for statistical fluctuations in results. Based on our anticipated enrollment of 2,000 lives, the adjustment provided in the AAA study is 12%. As such, this filing assumes a target loss ratio of 68%. Expenses will be managed internally around this level, including broker commissions.

10. Marketing Method:

CHL products are sold to individuals through CHL representatives and independent, licensed brokers and agents.

11. Underwriting:

Medical underwriting guidelines are applied consistently and fairly on all applicants.

12. Premium Classes:

CHL will offer one class of business.

13. Issue Age Ranges:

CHL will issue and renew until Medicare eligible due to age, except where limited by law.

14. Premium Modalization Rules:

Not applicable.

15. Active Life Reserves:

Active life reserves will be held under the guidance set forth in Arkansas law and regulation, NAIC guidelines, and Actuarial Standards of Practice.

COVENTRY
Health and Life Insurance Company

16. Trend Assumptions:

The maximum trend rate that will be applied is: 10%. Lower trend rates may apply based on emerging experience and expected future claims levels. This trend will only be applied upon renewal.

17. Rating Methodology

CHL will utilize age and gender specific rates.

18. Anticipated Loss Ratios:

The anticipated loss ratio for this block of business is 68.0%, as described in the expense section.

19. Past Experience and Lifetime Loss Ratio:

Since this is a new product and rate filing, there is no prior experience.

20. History of Rate Adjustments:

Since this is a new product and rate filing, there are no prior rate adjustments.

21. Numbers of Policyholders:

Since this is a new product and rate filing, there are no prior current members in the Arkansas service areas.

22. Proposed Effective Date:

The new rating factors are appropriate for contracts with January 1, 2011 effective dates.

23. Rates:

Please see attached rate pages (Attachment 2). Premium rates for individuals will vary by benefit plan design, underwriting, age/gender, and area. The development of projected base rates for 2011 was based on the experience of the recently acquired Mercy Health Plans experience in Arkansas, as shown in Attachment 3. We consider Attachment 3 proprietary. We respectfully request that it be kept confidential to the maximum extent permitted under law.

COVENTRY
Health and Life Insurance Company

24. Actuarial Certification:

I, James W. Brown, have reviewed the premium and claim experience used to develop the proposed rates for the individual products in Arkansas. I have relied on analysis provided by staff of Mercy Health Plan, and have reviewed the information for reasonableness.

I hereby certify that to the best of my knowledge and ability, the following are true with respect to this filing:

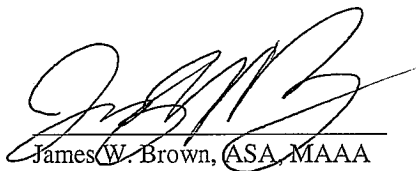
a. The assumptions present the actuary's best judgment as to the expected value for each assumption
and are consistent with the issuer's business plan at the time of the filing.

b. The filing is in compliance with applicable laws and regulations in the state.

c. The loss ratios comply with the regulatory loss ratio requirements.

d. The rates are adequate and reasonable in relationship to the benefits provided, and are not excessive or unfairly discriminatory between policyholders.

e. The rates comply with accepted actuarial practices.



10/8/2010
Date

James W. Brown, ASA, MAAA
Director
Coventry Health Care, Inc.
1100 Circle 75 Parkway
Atlanta, GA 30339
Phone: (678) 202-2145
E-Mail: jwbrown@cvty.com

Coventry Health and Life Insurance Company
Arkansas Individual - New Plans 2011
Attachment 1

	PLAN A		PLAN B		PLAN C		PLAN D		PLAN E		PLAN F		PLAN G	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Deductible	$1,000	$2,000	$2,500	$5,000	$5,000	$10,000	$1,000	$2,000	$1,500	$3,000	$2,500	$5,000	$5,000	$10,000
Coinsurance	80%	60%	80%	60%	80%	60%	80%	60%	80%	60%	80%	60%	80%	60%
Out of Pocket	$3,500	$7,000	$5,000	$10,000	$7,500	$15,000	$4,500	$9,000	$5,000	$10,000	$6,000	$12,000	$8,500	$17,000
Hospital	100%	75%	100%	75%	100%	75%	80%	60%	80%	60%	80%	60%	80%	60%
PCP Office Visit	$30	75%	$30	75%	$30	75%	$30	60%	$30	60%	$30	60%	$30	60%
Specialist	$60	75%	$60	75%	$60	75%	$60	60%	$60	60%	$60	60%	$60	60%
ER	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200
Urgent Care	$75	$200	$75	$200	$75	$200	$75	$200	$75	$200	$75	$200	$75	$200
Preventive Health	100%	75%	100%	75%	100%	75%	100%	60%	100%	60%	100%	60%	100%	60%
Ambulance	100%	100%	100%	100%	100%	100%	80%	80%	80%	80%	80%	80%	80%	80%
Chiropractor	Visit Limits		Visit Limits		Visit Limits		Visit Limits		Visit Limits		Visit Limits		Visit Limits	
Vision	$60		$60		$60		$60		$60		$60		$60	
Mental Health/Substance Abuse	Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above	
Hearing Aids/Service	Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above	
TMJ	Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above		Mandated Offer Rider; Covered under site of service listed above	
RX Tier 1	$10	50%	$10	50%	$10	50%	$10	50%	$10	50%	$10	50%	$10	50%
RX Tier 2	$35	50%	$35	50%	$35	50%	$35	50%	$35	50%	$35	50%	$35	50%
RX Tier 3	$70	50%	$70	50%	$70	50%	$70	50%	$70	50%	$70	50%	$70	50%
RX Tier 4	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%

* Maternity is not covered under these plans

** All essential benefits are unlimited from a dollar perspective, as required under PPACA

Coventry Health and Life Insurance Company
Arkansas Individual Plans
Age and Area Factors
January 1, 2011

Exhibit 2

Age Factors

Age Band	Male	Female
6 months - 1 yr	1.244	1.244
1-4	1.244	1.244
5-18	0.602	0.602
19-24	0.564	0.770
25-29	0.640	0.923
30-34	0.813	1.175
35-39	1.000	1.395
40-44	1.277	1.547
45-49	1.627	1.810
50-54	2.187	2.181
55-59	2.847	2.593
60-64	3.757	3.096
65+	3.757	3.096

Smoker Load:	20%
TMJ Rider Rate:	$2.20
MH/SA Rider Rate:	$8.65
Hearing Aid Rider Rate:	$1.90
Maximum Annual Trend:	10%

Area Factors

County	Region	Factor
Benton	NW Arkansas	0.90
Carroll	NW Arkansas	0.90
Madison	NW Arkansas	0.90
Washingt	NW Arkansas	0.90
Franklin	Fort Smith	1.00
Logan	Fort Smith	1.00
Scott	Fort Smith	1.00
Sebastian	Fort Smith	1.00
Clark	Hot Springs	1.10
Garland	Hot Springs	1.10
Hot Spring	Hot Springs	1.10
Montgome	Hot Springs	1.10
Pike	Hot Springs	1.10
Baxter	Springfield Border	0.92
Boone	Springfield Border	0.92
Fulton	Springfield Border	0.92
Marion	Springfield Border	0.92
Faulkner	Little Rock	1.05
Lonoke	Little Rock	1.05
Pulaski	Little Rock	1.05
Saline	Little Rock	1.05
White	Little Rock	1.05
All Other		1.35

REVISED October 1, 2010

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Attachment 3 - Premium Development/Projection
PROPRIETY and CONFIDENTIAL

ARK Mercy One Claims Experience from 7/1/2008 to 3/31/2009
Trended forward to July 1, 2011
Member Month Exposure: 36,606
Average Geographic Factor: 1.00
Average duration was 5.8 months, so utililzation adjusted by 26.2% to reflect average duration
Trend assumed at 10%

Net Paid Dollars	Total
Inpatient	$31.07
Outpatient	$50.70
Physician Services	$60.81
Pharmacy	$18.48
Other	$2.15
Sub Total	$163.20
Back out MH/SA (Mandated Offer Rider):	$1.34
Total Med Expense:	$161.86
Back out Average Age-Gender Factor in Experience:	1.288
Back out average UW load (estimated):	1.163
Male, age 37 Net Paid Claims PMPM:	$108.06
PPACA Adjustments	
Removal of Lifetime Limits:	0.25%
Removal of Annual DME Limit:	0.50%
$0 Preventive Cost Sharing:	2.00%
TOTAL PPACA IMPACT:	2.75%
ADJ Male, age 37 Net Paid Claims PMPM:	$111.03
Minimum Loss Ratio Target:	80%
American Academy of Actuaries 80% C.I. Credibility Adjustment	12%
* Assumes 2,000 average members	
Adjusted Target Loss Ratio:	68%
Projected Premium:	$162.76

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan A	217.98	217.98	239.78	239.78	217.98	217.98	196.18	196.18	200.54	200.54	294.27	294.27
1 - 4		217.98	217.98	239.78	239.78	217.98	217.98	196.18	196.18	200.54	200.54	294.27	294.27
5 - 18		105.45	105.45	116.00	116.00	105.45	105.45	94.91	94.91	97.02	97.02	142.36	142.36
19 - 24		98.79	134.92	108.67	148.41	98.79	134.92	88.91	121.43	90.89	124.13	133.37	182.14
25 - 29		112.05	161.73	123.26	177.90	112.05	161.73	100.85	145.55	103.09	148.79	151.27	218.33
30 - 34		142.40	205.88	156.64	226.47	142.40	205.88	128.16	185.29	131.01	189.41	192.25	277.94
35 - 39		175.22	244.43	192.74	268.87	175.22	244.43	157.70	219.99	161.20	224.88	236.55	329.98
40 - 44		223.68	271.06	246.05	298.17	223.68	271.06	201.31	243.96	205.79	249.38	301.97	365.94
45 - 49		285.16	317.15	313.67	348.86	285.16	317.15	256.64	285.43	262.34	291.78	384.96	428.15
50 - 54		383.29	382.15	421.61	420.37	383.29	382.15	344.96	343.94	352.62	351.58	517.43	515.91
55 - 59		498.85	454.34	548.74	499.78	498.85	454.34	448.97	408.91	458.94	418.00	673.45	613.36
60 - 64		658.32	542.48	724.15	596.73	658.32	542.48	592.49	488.23	605.65	499.08	888.73	732.35

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan B	183.39	183.39	201.73	201.73	183.39	183.39	165.05	165.05	168.72	168.72	247.58	247.58
1 - 4		183.39	183.39	201.73	201.73	183.39	183.39	165.05	165.05	168.72	168.72	247.58	247.58
5 - 18		88.72	88.72	97.59	97.59	88.72	88.72	79.85	79.85	81.62	81.62	119.77	119.77
19 - 24		83.11	113.51	91.43	124.86	83.11	113.51	74.80	102.16	76.46	104.43	112.20	153.24
25 - 29		94.27	136.06	103.70	149.67	94.27	136.06	84.85	122.46	86.73	125.18	127.27	183.69
30 - 34		119.81	173.21	131.79	190.53	119.81	173.21	107.83	155.89	110.22	159.36	161.74	233.84
35 - 39		147.42	205.64	162.16	226.21	147.42	205.64	132.67	185.08	135.62	189.19	199.01	277.62
40 - 44		188.19	228.05	207.01	250.86	188.19	228.05	169.37	205.25	173.13	209.81	254.05	307.87
45 - 49		239.91	266.82	263.90	293.50	239.91	266.82	215.92	240.14	220.71	245.48	323.87	360.21
50 - 54		322.46	321.51	354.71	353.66	322.46	321.51	290.22	289.36	296.67	295.79	435.33	434.04
55 - 59		419.69	382.25	461.66	420.47	419.69	382.25	377.72	344.02	386.12	351.67	566.59	516.03
60 - 64		553.85	456.40	609.24	502.04	553.85	456.40	498.47	410.76	509.55	419.89	747.70	616.14

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan C	154.88	154.88	170.37	170.37	154.88	154.88	139.39	139.39	142.49	142.49	209.09	209.09
1 - 4		154.88	154.88	170.37	170.37	154.88	154.88	139.39	139.39	142.49	142.49	209.09	209.09
5 - 18		74.93	74.93	82.42	82.42	74.93	74.93	67.43	67.43	68.93	68.93	101.15	101.15
19 - 24		70.19	95.86	77.21	105.45	70.19	95.86	63.17	86.28	64.58	88.20	94.76	129.42
25 - 29		79.62	114.91	87.58	126.40	79.62	114.91	71.66	103.42	73.25	105.72	107.48	155.13
30 - 34		101.18	146.29	111.30	160.92	101.18	146.29	91.06	131.66	93.09	134.58	136.60	197.49
35 - 39		124.50	173.68	136.95	191.04	124.50	173.68	112.05	156.31	114.54	159.78	168.07	234.46
40 - 44		158.93	192.60	174.83	211.86	158.93	192.60	143.04	173.34	146.22	177.19	214.56	260.01
45 - 49		202.61	225.34	222.87	247.88	202.61	225.34	182.35	202.81	186.40	207.32	273.53	304.21
50 - 54		272.34	271.53	299.57	298.69	272.34	271.53	245.10	244.38	250.55	249.81	367.65	366.57
55 - 59		354.45	322.83	389.90	355.11	354.45	322.83	319.01	290.54	326.10	297.00	478.51	435.82
60 - 64		467.76	385.45	514.53	423.99	467.76	385.45	420.98	346.90	430.34	354.61	631.47	520.36

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan D	202.48	202.48	222.73	222.73	202.48	202.48	182.23	182.23	186.28	186.28	273.35	273.35
1 - 4		202.48	202.48	222.73	222.73	202.48	202.48	182.23	182.23	186.28	186.28	273.35	273.35
5 - 18		97.95	97.95	107.75	107.75	97.95	97.95	88.16	88.16	90.12	90.12	132.24	132.24
19 - 24		91.77	125.33	100.94	137.86	91.77	125.33	82.59	112.79	84.43	115.30	123.88	169.19
25 - 29		104.09	150.23	114.50	165.25	104.09	150.23	93.68	135.21	95.76	138.21	140.52	202.81
30 - 34		132.28	191.24	145.51	210.37	132.28	191.24	119.05	172.12	121.70	175.95	178.58	258.18
35 - 39		162.76	227.05	179.04	249.76	162.76	227.05	146.49	204.35	149.74	208.89	219.73	306.52
40 - 44		207.78	251.79	228.56	276.97	207.78	251.79	187.00	226.61	191.16	231.65	280.50	339.92
45 - 49		264.88	294.60	291.37	324.06	264.88	294.60	238.39	265.14	243.69	271.03	357.59	397.71
50 - 54		356.03	354.98	391.64	390.48	356.03	354.98	320.43	319.48	327.55	326.58	480.65	479.23
55 - 59		463.39	422.04	509.72	464.24	463.39	422.04	417.05	379.84	426.31	388.28	625.57	569.76
60 - 64		611.51	503.91	672.66	554.30	611.51	503.91	550.36	453.52	562.59	463.60	825.54	680.28

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan E	189.85	189.85	208.84	208.84	189.85	189.85	170.87	170.87	174.66	174.66	256.30	256.30
1 - 4		189.85	189.85	208.84	208.84	189.85	189.85	170.87	170.87	174.66	174.66	256.30	256.30
5 - 18		91.84	91.84	101.03	101.03	91.84	91.84	82.66	82.66	84.50	84.50	123.99	123.99
19 - 24		86.04	117.51	94.65	129.26	86.04	117.51	77.44	105.76	79.16	108.11	116.16	158.64
25 - 29		97.60	140.86	107.35	154.94	97.60	140.86	87.84	126.77	89.79	129.59	131.75	190.16
30 - 34		124.03	179.32	136.43	197.25	124.03	179.32	111.63	161.38	114.11	164.97	167.44	242.08
35 - 39		152.61	212.89	167.87	234.18	152.61	212.89	137.35	191.60	140.40	195.86	206.02	287.40
40 - 44		194.82	236.09	214.30	259.69	194.82	236.09	175.34	212.48	179.23	217.20	263.00	318.72
45 - 49		248.36	276.22	273.20	303.84	248.36	276.22	223.52	248.60	228.49	254.12	335.29	372.90
50 - 54		333.83	332.84	367.21	366.12	333.83	332.84	300.44	299.56	307.12	306.21	450.67	449.33
55 - 59		434.48	395.72	477.93	435.29	434.48	395.72	391.03	356.14	399.72	364.06	586.55	534.22
60 - 64		573.37	472.48	630.71	519.73	573.37	472.48	516.03	425.23	527.50	434.68	774.05	637.84

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan F	172.08	172.08	189.29	189.29	172.08	172.08	154.87	154.87	158.32	158.32	232.31	232.31
1 - 4		172.08	172.08	189.29	189.29	172.08	172.08	154.87	154.87	158.32	158.32	232.31	232.31
5 - 18		83.25	83.25	91.57	91.57	83.25	83.25	74.92	74.92	76.59	76.59	112.38	112.38
19 - 24		77.99	106.51	85.79	117.16	77.99	106.51	70.19	95.86	71.75	97.99	105.29	143.79
25 - 29		88.46	127.67	97.31	140.44	88.46	127.67	79.61	114.91	81.38	117.46	119.42	172.36
30 - 34		112.42	162.53	123.66	178.79	112.42	162.53	101.18	146.28	103.43	149.53	151.77	219.42
35 - 39		138.33	192.96	152.16	212.26	138.33	192.96	124.49	173.67	127.26	177.53	186.74	260.50
40 - 44		176.58	213.99	194.24	235.39	176.58	213.99	158.92	192.59	162.46	196.87	238.39	288.89
45 - 49		225.11	250.37	247.62	275.41	225.11	250.37	202.60	225.33	207.10	230.34	303.90	338.00
50 - 54		302.58	301.69	332.84	331.86	302.58	301.69	272.32	271.52	278.37	277.55	408.48	407.28
55 - 59		393.81	358.68	433.20	394.54	393.81	358.68	354.43	322.81	362.31	329.98	531.65	484.21
60 - 64		519.70	428.25	571.67	471.08	519.70	428.25	467.73	385.43	478.13	393.99	701.60	578.14

Coventry Health and Life Insurance Company
Arkansas Individual Rates 2011
Non-tobacco Rates

		Fort Smith		Hot Springs		Little Rock		NW Arkansas		Springfield Border		Other	
Age Bands		**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
6 months - 1 yr	Plan G	140.98	140.98	155.08	155.08	140.98	140.98	126.88	126.88	129.70	129.70	190.32	190.32
1 - 4		140.98	140.98	155.08	155.08	140.98	140.98	126.88	126.88	129.70	129.70	190.32	190.32
5 - 18		68.20	68.20	75.02	75.02	68.20	68.20	61.38	61.38	62.74	62.74	92.07	92.07
19 - 24		63.89	87.26	70.28	95.98	63.89	87.26	57.50	78.53	58.78	80.28	86.25	117.80
25 - 29		72.47	104.60	79.72	115.06	72.47	104.60	65.22	94.14	66.67	96.23	97.84	141.20
30 - 34		92.10	133.15	101.31	146.47	92.10	133.15	82.89	119.84	84.73	122.50	124.33	179.76
35 - 39		113.32	158.08	124.65	173.89	113.32	158.08	101.99	142.28	104.26	145.44	152.98	213.41
40 - 44		144.66	175.31	159.13	192.84	144.66	175.31	130.20	157.78	133.09	161.28	195.30	236.67
45 - 49		184.42	205.11	202.87	225.62	184.42	205.11	165.98	184.60	169.67	188.70	248.97	276.90
50 - 54		247.89	247.16	272.68	271.87	247.89	247.16	223.10	222.44	228.06	227.38	334.65	333.66
55 - 59		322.63	293.84	354.89	323.23	322.63	293.84	290.37	264.46	296.82	270.34	435.55	396.69
60 - 64		425.76	350.85	468.34	385.93	425.76	350.85	383.19	315.76	391.70	322.78	574.78	473.64

Health Care Benefits

Arkansas

PREFERRED PROVIDER ORGANIZATION ("PPO")

INDIVIDUAL POLICY

IMPORTANT NOTICE

THIS POLICY, THE APPLICATION AGREEMENT AND ALL ATTACHED RIDERS SHOULD BE READ IN THEIR ENTIRETY.

Carefully check the application agreement and write to Coventry Health & Life Insurance Company at the address listed below, within ten (10) days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application agreement. This application agreement is part of the Policy and the Policy was issued on the basis that answers to all questions and the information shown on the application agreement are correct and complete. You may return this Policy within ten (10) days of its receipt for a full refund of any Premiums paid if, after examining it, You are not satisfied for any reason.

The Insured has the full freedom of choice in the selection of any duly licensed health care professional. This Policy has provisions reducing the amount of Coverage the Insured receives depending on which Physicians or other health care providers are used. Please consult this Policy, the Schedule of Benefits and Provider Directory for more details. If you have any additional questions, please write or call us at:

Coventry Health & Life Insurance Company
[8320 Ward Parkway]
[Kansas City, MO 64114]
[(800) 969-3343]
[www.chckansas.com]

Welcome to Coventry Health & Life Insurance Company!

We are extremely pleased to have You enrolling in our Plan and look forward to serving You. We have built a strong network of area Physicians, Hospitals, and other providers to offer a broad range of services for Your medical needs.

As a Coventry Health & Life Insurance Company Insured, it is important that You understand the way Your Plan operates. This Policy contains the information You need to know about Your Coverage with us.

Please take a few minutes to read these materials so that You are aware of the provisions of Your Coverage. Our Customer Service Department is available to answer any questions You may have about Your Coverage. You can reach them at the number listed in the Schedule of Important Numbers Monday through Thursday, 8:00 a.m. to 6:00 p.m., Friday, 8:00 a.m. to 5:00 p.m. Central Standard Time. You can also check the Plan's website at www.chckansas.com any time for additional information.

We look forward to serving You.

Sincerely,

[Michael Murphy]

Chief Executive Officer

This Policy is guaranteed renewable to age 65 or eligibility for Medicare subject to the termination provisions in Eligibility & Termination. Premium rates may be changed on a class basis.

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Coventry Health & Life Insurance Company
Individual Policy

The Policy between **Coventry Health & Life Insurance Company** (hereafter called the "Plan") and You is made up of:

- This Policy and Amendments;
- Application Form;
- Applicable Riders;
- Provider Directory; and
- Schedule of Benefits.

No person or entity has any authority to waive any Policy provision or to make any changes or Amendments to this Policy unless approved in writing by an Officer of the Plan, and the resulting waiver, change, or Amendment is attached to the Policy. This Policy begins on the date defined in the proposal rate acceptance, and continues until replaced, or terminated. You are subject to all terms, conditions, limitations, and exclusions in this Policy and to all the rules and regulations of the Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of this Policy.

THE POLICY SHOULD BE READ IN ITS ENTIRETY. By carefully reading this Policy and understanding Your relationship to the Plan, You can be an informed participant. You should keep this Policy in a safe place for Your future reference. Many of the provisions of this Policy are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Policy will appear capitalized because they have special meaning and are defined for You. By using these definitions, You will have a clearer understanding of Your Coverage. From time to time, the Policy may be amended. When that occurs, the Plan will provide an Amendment or a new Policy to You.

The Plan is responsible for making benefit determinations in accordance with this Policy and the Plan's agreements with Participating Providers. The Plan does not and will not make medical treatment decisions. Only Providers may make such decisions after meeting with You. If the Plan denies a claim for payment or Pre-Certification of a recommended service, You may request reconsideration of that decision through the Plan's Complaint and Grievance Procedure described in this Policy.

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Table of Contents

Any capitalized terms listed shall have the meaning set forth below whenever the capitalized term is used in this Policy.

"Activities of Daily Living"

Activities you usually do during a normal day including but not limited to bathing, dressing, eating, maintaining continence, toileting, transferring from bed to chair, and mobility.

"Acute"

Refers to an Illness or Injury that is both severe and of recent onset.

"Administrative Appeal"

An Appeal of a decision that has not been issued for medical necessity or medical appropriateness, but is administrative in nature, for example, appealing a Copayment, Coinsurance, or exclusion associated with a Covered Service.

"Adverse Benefit Determination"

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination may be based in whole or in part on a medical judgment and may also include:

- Any reduction or termination of a benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to not be Medically Necessary or medically appropriate;
- The failure to cover services because they are cosmetic;
- The failure, reduction, or termination regarding the availability and/or delivery of health care services;
- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services; and/or
- The failure, reduction, or termination regarding terms of the contractual relationship between Insured and the Plan.

"Alternate Facility"

A duly-licensed non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received, including without limitation:

- Scheduled surgical services;
- Emergency services;
- Urgent Care Services;
- Prescheduled rehabilitative services;
- Laboratory or diagnostic services;
- Inpatient or outpatient Mental Illness services or Substance Abuse services.

"Amendment"

Any attached written description of additional or alternative provisions to the Policy and/or this Policy. Amendments are effective only when Authorized in writing by the Plan and are subject to

all conditions, limitations and exclusions of the Policy except for those which are specifically amended.

"Ancillary Provider"

A Provider who is not licensed as a Physician or a Hospital.

"Appeal"

An Appeal is a request by You or Your Authorized Representative for consideration of an Adverse Benefit Determination of a service request or benefit that You believe You are entitled to receive.

"Authorized Representative"

An Authorized Representative is an individual authorized in writing or verbally by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for Health Insurance Portability and Accountability Act ("HIPAA") privacy purposes.

"Benefit Maximum"

A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for the Insured in any one Benefit Year. Once a Benefit Maximum is met, no more Covered Services will be provided during the same Benefit Year.

"Benefit Year"

The period of time during which the total amount of annual benefits under Your Coverage is calculated. Your policy may be issued on either a Calendar Year or Contract Year. Please call the customer service number on the back of your ID card to obtain information about Your Benefit Year.

"Calendar Year"

The period of time from January 1 through December 31 inclusive. This is the period during which the total amount of annual benefits under Your Coverage is calculated.

"Chronic Condition"

A health condition that is continuous or persistent over an extended period of time.

"Coinsurance"

Cost-sharing arrangement in which the Insured pays a specified percentage of the cost for a Covered Service.

"Coinsurance Maximum"

The annual limit of a Insured's coinsurance payments for Covered Services, as specified in the Schedule of Benefits"

"Complaint"

Any dissatisfaction expressed by You or Your Authorized Representative regarding a Plan issue.

"Confinement" and "Confined"

An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.

"Contract Year"

The period during which the total amount of yearly benefits under Your Coverage is calculated. The Contract Year is the period of twelve (12) consecutive months commencing on the Effective

Date and each subsequent anniversary.

"Copayment"

Cost-sharing arrangement in which the Insured pays a specified dollar amount as their share of the cost for a Covered Service.

"Cosmetic Services and Surgery"

Services performed to reshape structures of the body in order to alter appearance, to alter the aging process, or when performed primarily for psychological purposes. Cosmetic Services are not needed to correct or substantially improve a bodily function.

"Coverage" or "Covered"

The entitlement by the Insured to Covered Services under this Policy, subject to the terms, conditions, limitations and exclusions of the Policy, including the following conditions: (a) services must be provided when this Policy is in effect; and (b) services must be provided prior to the date that any of the termination conditions listed in this Policy occur; and (c) services must be provided only when the recipient is the Insured and meets all eligibility requirements specified in this Policy; and (d) services must be Medically Necessary.

"Covered Services"

The services or supplies provided to You for which the Plan will make payment, as described in the Policy.

"Custodial Care"

Care is considered custodial when it is primarily for the purpose of helping the Insured with Activities of Daily Living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. This term includes such other care that is provided to the Insured who, in the opinion of the Medical Director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized Insured, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to, respite care and home care which is or which could be provided by family members or private duty caregivers.

"Deductible"

The dollar amount of medical expenses for Covered Services that You are responsible for paying annually before benefits subject to the Deductible are payable under this Policy.

"Dental Services"

Services primarily for the prevention, diagnosis and treatment of diseases and injuries to the oral cavity, the teeth, and their surrounding structures.

"Dependent"

Any member of an Insured's family who meets the eligibility requirements and who is properly enrolled for Coverage under the Agreement and on whose behalf Premiums are paid.

"Designated Transplant Network Facility"

A Hospital appointed as a Designated Transplant Network Facility by the Plan, to render Medically Necessary and medically appropriate services for Covered transplants. You may request a listing that may be amended from time to time, of Designated Transplant Network Facilities from the Customer Service Department listed in the Schedule of Important Numbers.

"Designated Transplant Network Physician"

A Physician appointed as a Designated Transplant Network Physician by the Plan, who has entered into an agreement with a Designated Transplant Network Facility to render Medically

Necessary and medically appropriate services for Covered transplants.

"Durable Medical Equipment"

Medical equipment Covered under this Policy or attached Rider, which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an Illness or Injury, and is appropriate for use in the home. Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of Durable Medical Equipment will be considered Durable Medical Equipment.

"Elective Abortion"

An abortion for any reason other than a spontaneous abortion or to prevent the death of the Insured upon whom the abortion is performed.

"Eligible Expenses"

Charges for Covered Services, incurred while the Policy is in effect.

"Emergency Medical Condition" and "Medical Emergency"

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing the Insured's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part; or
- Inadequately controlled pain.

Some examples of an Emergency Medical Condition include, but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing; or
- Vaginal bleeding during pregnancy.

The Insured may seek medical attention from a Hospital, Physician's office or some other Emergency facility.

"Emergency Services"

Generally, Eligible Expenses for Emergency Services are the charges for the services provided during the course of the Emergency, and when Medically Necessary for stabilization and initiation of treatment. The Emergency Services must be provided by or under the direction of a Physician, and are subject to the exclusions and other provisions set out in this Policy.

"Experimental or Investigational"

A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the Federal Food and Drug Administration ("FDA"); any drug that is classified as an Investigational New Drug ("IND") by the FDA; or any drug that is proposed for off-label prescribing. As used herein, off-label prescribing

means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.

- Off-label prescribing for the treatment of cancer is not considered Experimental or Investigational.
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval.
  - Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered.
- Any health product or service whose effectiveness is unproven or is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts.

"FDA"

Federal Food and Drug Administration.

"Home Health Agency"

An organization that meets all of these tests: (a) its main function is to provide home health care services and supplies; (b) it is federally certified as a home health care agency; and (c) it is licensed by the state in which it is located, if licensing is required.

"Home Health Care Services"

Skilled nursing care and intermittent home health aide services provided in your home through a home health care agency, including physical therapy, speech therapy, occupational therapy, and medical supplies for the treatment of an illness or injury.

"Hospice"

An organization or entity whose primary purpose is to furnish medical services and supplies only to patients who are considered to be terminally ill. The Plan has the right to determine whether a facility is a Hospice facility.

"Hospital"

An institution, operated pursuant to law, which: (a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; and (b) has twenty-four (24) hour nursing services on duty or on call. For the purpose of this definition, a facility that is primarily a place for rest, Custodial Care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

"Illness"

Physical ailment, or disease. For the purpose of this definition, the term Illness does not apply to Mental Illness or Substance Abuse.

"IND"

Investigational New Drug.

"Individual Contract"

A contract for health care services issued to and covering an individual Insured.

"Infertility"

Any medical condition causing the inability or diminished ability to reproduce.

"Infertility Services"

Those services including confinement, treatment or services related to the restoration of fertility or the promotion of conception.

"Injury"

Bodily damage, other than Illness, including all related conditions and recurrent symptoms.

"Inquiry"

Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.

"Insured"

Any Policy Holder or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for Coverage under this Agreement in accordance with its terms and conditions and for whom, or on whose behalf, Premiums have been received and accepted by the Plan.

"Institutional Review Board ("IRB")"

A university or Participating Hospital panel composed of faculty and researchers that evaluates experimental and investigational procedures.

"Maintenance Therapy"

A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition.

"Material Misrepresentation"

Medical or other information not disclosed on the application, or as it relates to Covered Services, which, if it had been disclosed, would have affected the acceptance of coverage, benefits offered or provided and/or Premium charged.

"Maternity Services"

Includes prenatal and postnatal care, childbirth, and any complications associated with pregnancy.

"Medical Director"

The Physician specified by the Plan, or his or her designee, and appropriately licensed in the practice of medicine in accordance with state law, who is responsible for medical oversight programs, including but not limited to Pre-Certification programs.

"Medically Necessary/Medical Necessity"

Medically Necessary means those services, supplies, equipment and facility charges that are not expressly excluded under this Policy and are:

- Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- Necessary to meet Your health needs, improve physiological function and required for a reason other than improving appearance;
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the service;
- Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental

agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;

- Consistent with the diagnosis of the condition at issue;
- Required for reasons other than Your comfort or the comfort and convenience of Your Physician; and
- Not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

"Medical Necessity Appeal"

An Appeal of a determination by the Plan or its designated utilization review organization that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and payment for the service is denied, reduced or terminated.

"Medicare"

Part A and Part B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

"Mental Health and Substance Abuse Designee"

The organization, entity or individual that provides or arranges Covered Mental Health and Substance Abuse services under contract to the Plan.

"Mental Illness" or "Mental Health"

Those conditions classified as "mental disorders" in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders but not including mental retardation.

"NIH"

National Institutes of Health.

"Non-Participating Provider"

A Provider who has no direct or indirect written agreement with the Plan to provide Covered Services to Insureds.

"Officer"

The person holding the office of President and/or CEO or his or her designee.

"Orthotic Appliances"

Orthotic Appliances correct or support a defect of a body form or function.

"Out-of-Pocket Maximum"

The annual limit of an Insured's payments for Covered Services, as specified in the Schedule of Benefits.

"Participating Provider"

A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to the Insured.

"Peer-Reviewed Medical Literature"

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications

that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

"Physician/Practitioner"

Means anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the Degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Physician also means Doctors of Dentistry, Chiropractic and Podiatry when they are acting within the scope of their license.

By use of this term, the Plan recognizes and accepts, to the extent of the Plan's obligation under the Policy, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.

"Plan"

Coventry Health & Life Insurance Company.

"Policy"

This document and Amendments, applicable Riders, Provider Directory, and the Schedule of Benefits together form the Policy.

"Policy Holder"

An applicant, who has elected the Plan's Coverage for himself and eligible Dependents through submission of an application form and in who's name the Policy is issued.

"Post-Service Appeal"

An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

"Pre-Certification"

The Plan has given approval on a Pre-Service request for payment for Covered Services to be rendered by a Participating or Non-Participating Provider. Pre-Certification does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

"Preventive Services"

Shall mean the services set forth in Section 2713(a)(1) of the federal Public Health Service Act. A list of the preventive services covered available on our website at [www.chckansas.com] or will be mailed to you upon request.

"Pre-Existing Condition"

Any condition for which You received medical advice, diagnosis, care, treatment or recommended treatment from an individual licensed or similarly authorized to provide such services under applicable state law within the twelve (12) month period prior to the effective date of your Coverage. A condition may be defined as Pre-Existing whether physical or mental, and regardless of the cause of the condition. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition relating to such information.

"Pre-Existing Condition Exclusion Period"

The period of time for which Covered Services are excluded for a Pre-Existing Condition. The Pre-Existing Condition Exclusion Period begins on Your Effective Date of Coverage.

"Pre-Service Appeal"

An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Pre-Certification.

"Premium"

The monthly fee required from Insured in accordance with the terms of the Policy.

"Prosthetic Devices"

Prosthetic Devices aid body functioning or replace a limb or body part. Prosthetic Devices can be either internally or externally placed.

"Provider"

A Physician, Hospital, or Ancillary Provider or other duly licensed health care facility or practitioner, certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received.

"Provider Directory"

A listing of Participating Providers. Please be aware that the information in the directory is subject to change and will be updated at least annually.

"Reconstructive Surgery"

Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) The definition of Reconstructive Surgery includes the following: reconstructive surgery following a mastectomy, including on the opposite breast to restore symmetry and Prosthetic Devices/implants or reduction mammoplasty; and reconstructive surgery for a Covered newborn.

"Reformation"

Amendment of benefits, Coverage or Premium charged to a level or form different than originally issued to an Insured. The Plan may initiate adjustments to Premium in the event of a Material Misrepresentation that led the Plan to provide Coverage at the original rates quoted.

"Reinstatement"

Means restoring a Policy that has been terminated for example, because of nonpayment of Premiums.

"Rescission or Rescind"

Termination of Your Coverage, retroactive to the effective date of Coverage under this Policy. When Coverage is rescinded, the Plan refunds all Premiums paid, and recovers all payments made on behalf of the applicant. Therefore, the Plan and You are returned to a financial position as if no Coverage had ever been in force. The Plan may initiate this action in the event of a Material Misrepresentation that led to the issuance of Coverage under the Policy.

"Rider"

An Amendment that modifies Covered services and is attached to the Policy. Services provided by a Rider may be subject to payment of additional Premiums.

"Self-Injectables"

Injectable Prescription Drugs as specified in the Plan's formulary list, that are commonly and customarily administered by the Insured according to clinical guidelines used by the Plan.

"Semi-private Accommodations"

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations

are Medically Necessary.

"Service Area"

The geographic area served by the Plan. The Plan's Service Area is subject to change from time to time.

"Skilled Nursing Facility ("SNF")"

A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related services. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily Custodial Care, including training in Activities of Daily Living.

"Substance Abuse"

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

"Therapeutic Injections and IV Infusions"

Prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the Insured.

"Total Disability"

Complete inability of the Insured to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Insured to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. The disability of the Insured must require regular care and attendance by a Physician who is someone other than an immediate family member.

"Urgent Care"

A condition that requires prompt medical attention due to an unexpected Illness or Injury. These conditions may also constitute Emergencies in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

"Urgent Care Appeal"

An Appeal for which a requested service requires Pre-Certification, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of the Insured or the Insured's unborn child; or (b) the Insured's ability to regain maximum function. In determining whether an Appeal involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

"Utilization Review"

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, Pre-Certification, concurrent review, case management, and discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of Coverage.

"We, Us or Our"

Coventry Health & Life Insurance Company.

"You or Your"

The Insured Covered under this Policy.

Acceptance Of This Policy

By selecting Coverage pursuant to this Policy, and by seeking or accepting care or Covered Services, You agree to all of the terms, conditions, and provisions of this Policy, including any Riders and Amendments hereto.

Identification ("ID") Card

Every Insured will receive an ID card. Carry Your ID card with You at all times, and present it every time You request or receive services. The ID card is needed for Providers to bill the Plan for charges other than Copayments, Coinsurance, and non-Covered Services. If You do not show Your ID card, the Providers cannot identify You as an Insured of the Plan, and You may receive a bill for services. If Your ID card is missing, lost, or stolen, contact the Plan's Customer Service Department at [800-969-3343] or through the website at [www.chckansas.com] to obtain a replacement. This information is also listed on the ID card and in the Schedule of Important Numbers. Possession and use of an ID card is not an entitlement to Coverage. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in this Policy.

Health Services Rendered By Participating Providers

An Insured has access to the services of a Participating Provider of their choice within the Provider network when receiving In-Network Covered Services, subject to the terms, conditions, exclusions and limitations of the Policy. Coverage for services described in this Policy and the Schedule of Benefits include services that (a) are Medically Necessary and (b) are provided by or under the direction of a Participating Provider and (c) are Pre-Certified, if required, in advance. The telephone number for Pre-Certification is listed on Your ID card and in The Schedule Of Important Telephone Numbers And Addresses of this Policy. Participating Providers are contractually obligated to file all claims for You.

It is the Insured's responsibility to verify the participation status of Providers. You should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Insured is responsible for verifying the status of the Provider by contacting the Customer Service Department or by checking the Plan's website at [www.chckansas.com].

Coverage for services is subject to timely payment of the Premium required for Coverage under the Plan and payment of the Copayment, Coinsurance and/or Deductible specified for any service. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not the Provider. To verify Coverage of services or Provider participation status, please contact the Customer Service Department.

Notice of Claim

The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits. A Non-Participating Provider may or may not complete and file the claim form for You. Written notice of claim must be submitted to the Plan within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonable.

Claim Forms

You may obtain a Non-Participating claim form from the Plan's Customer Service Department

within fifteen (15) days from the date the Plan receives notice of a claim from You. If a Non-Participating claim form is not provided to You within fifteen (15) days after the Plan receives notice of a claim, You shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting written proof covering the occurrence, character, and extent of loss, within the time fixed for filing a claim.

Proofs of Loss

It is your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of your claim. The Plan requests that You file the Non-Participating Provider claim within ninety (90) days from date of service. However, failure to file the claim within the ninety (90) day period shall not invalidate or reduce the claim, if it was not reasonably possible to provide notice or proof within the ninety (90) days. A claim will not be denied based upon the Insured's failure to submit a claim within the ninety (90) day period. However, claims may not be accepted, except in the absence of legal capacity of the claimant, when You submit proof of loss to the Plan more than twelve (12) months from the date services were provided by the Non-Participating Provider.

Processing of the Filed Claim

We make claim payment decisions based on the information provided on the submitted claim form. We make every effort to process claims upon receipt of the Proof of Loss. All Covered Services payable under the Policy shall be paid not more than thirty (30) days after receipt of the completed claim form, and subject to the Proof of Loss provision of this Policy. If We deny all or part of Your claim, We will send You an Explanation of Benefits form or a letter explaining why it was denied under the terms of the Policy. We will also notify You if additional information is necessary to process the claim.

Non-Participating Provider Fees

Payment for Covered Services provided by Non-Participating Providers is limited to the lesser of the billed charge or the Out-of-Network rates listed below less applicable Copayments, Coinsurance and/or Deductibles. These rates are calculated as a multiple of the Medicare fee schedule for Physicians, Hospitals, outpatient facilities, ancillary providers and other providers. These rates may be adjusted from time to time.

If the amount You are charged for a Covered Service is equal to or less than the Out-of-Network rate, the charge should be completely covered by Your Out of Network benefit, except for any Copayment, Coinsurance, and/or Deductible payments You must make. However, if the amount You are charged is in excess of the Out-of-Network rate for a particular Covered Service, you will be responsible for paying any amounts in excess of the rates listed below, in addition to any applicable Copayment, Coinsurance, and/or Deductible payments.

- **Non-Participating Physician and Other Health Care Professional Fees**
  The Out-of-Network rate is equivalent to 100% of the national average Medicare rate, based on the prior year Resource Based Relative Value Scale ("RBRVS") fee schedule for Physician and other health care profession services, as such services are defined in the American Medical Association's Current Procedural Terminology ("CPT") manual. For Physician and other health care profession services not valued in RBRVS, other Medicare or nationally recognized schedules will be used. For CPT codes developed after the prior year, the rate will be calculated using the assigned Relative Value Units ("RVU") and the prior year Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the First Data Bank Average wholesale Price ("AWP"). Payment for

anesthesia services will be 200% of the prior year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment ("DME"), prosthetics, orthotics and supplies ("DME POS") will be at the prior year DME POS ceiling limit. Payment for Laboratory services will be at the prior year Medicare Clinical Laboratory Fee Schedule. If there is no corresponding rate, as described above, for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.

- **Non Participating Facility Fees**
  The Out-of-Network rate is equivalent to 100% of the Medicare base rate for facility charges. Payment for inpatient services will be based on Diagnosis Related Group ("DRG") rates. Payment for outpatient services will be based on Ambulatory Payment Classification ("APC") rates. Payment for services provided within an ambulatory surgical center will be based on Ambulatory Surgical Center ("ASC") group rates. If there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.

Please note that Physician and Hospital charges typically are not regulated. Billed charges can vary tremendously from one provider to the next, so please make sure you are aware of the billed charge for services you want to receive from Non-Participating Providers.

Pre-Certification

Pre-Certification is required for certain Covered Services as determined by the Plan, such services include Hospital Admissions and related services, selected outpatient procedures, and all transplants. It is the Insured's responsibility to verify that Pre-Certification has been obtained from the Plan prior to receiving Covered Services. A list of current Pre-Certification procedures is provided to You. To request a copy contact the Plan's Customer Service Department's telephone number listed on Your ID card or by visiting the Plan's website at [www.chckansas.com].

Any new, additional or extended services not Covered under the original Pre-Certification will be Covered only if a new Pre-Certification is obtained. All services identified in this Policy are subject to all of the terms, conditions, exclusions and limitations of the Plan, even if the Participating Provider requests the Pre-Certification on behalf of the Insured.

Failure to obtain Pre-Certification will result in a reduction of benefits. To find out the amount of the penalty, please see the Schedule of Benefits. Any penalty applied does not apply to the Out-of-Pocket Maximum, the Deductible or Coinsurance amount. It is the Insured's responsibility to verify that Pre-Certification has been obtained before receiving services.

It is important to note that under the terms of the Plan, Pre-Certification only determines medical necessity and appropriateness, all other terms of the Plan are then applied. If the Plan Pre-Certifies Covered Services, the Plan shall not subsequently retract the Pre-Certification after the Covered Services have been received, or reduce payment unless: (1) Such Pre-Certification is based on a Material Misrepresentation or omission about the Insured's health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) the Insured's Coverage under the Plan terminates before the health care services are provided.

Second Opinion Policy

An Insured may seek a second medical opinion or consultation from any Provider. An Insured

should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits and subject to the terms, conditions, exclusions and limitations of the Policy.

Copayments, Coinsurance and Deductibles

You are responsible for paying Copayments to Providers at the time of service. The Provider may bill You at a later time for the Coinsurance amounts that are Your responsibility under the terms of the Plan as determined by the contracted rates that have been established between the Plan and the Participating Providers or as determined by the Plan's Non-Participating Provider fee schedule when services are rendered by a Non-Participating Provider. You must meet the applicable Deductible, as described in your Schedule of Benefits, before benefits will be payable to Providers on Your behalf. Specific Copayments, Coinsurance amounts and Deductibles are listed in the Schedule of Benefits. A Copayment is defined as a dollar amount, while Coinsurance is typically defined as a percentage of Eligible Expenses.

How to Contact The Plan

Throughout this Policy, You will find that the Plan encourages You to contact the Plan for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact the Plan at the telephone number or website on the back of Your ID card.

Telephone numbers and addresses to request review of denied claims, register Complaints, place requests for Pre-Certification, and submit claims are listed in the Schedule of Important Telephone Numbers And Addresses included in this Policy.

Participating Provider Hold Harmless

Participating Providers agree that in no event, including but not limited to nonpayment by the Plan or intermediary, insolvency of the Plan or intermediary, or breach of this Policy, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against the Insured or a person, other than the Plan or intermediary, acting on behalf of the Insured for services provided pursuant to this Policy. This Policy shall not prohibit the Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the EOC, or fees for non-Covered Services delivered on a fee-for-service basis to You. The provider hold harmless provision shall not prohibit a Provider and You from agreeing to continue services solely at Your expense, as long as the Provider has clearly informed You that the Plan may not cover or continue to cover a specific service or services. Except as provided herein, this provision does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing Coverage to You.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Policy. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Illness or Substance Abuse, or Mental Illness does not mean that the procedure or treatment is Covered under the Policy. The Plan shall have the right, subject to Your rights under this Policy, to interpret the benefits of this Policy and attached Riders, and other terms, conditions, limitations and exclusions set out in the Policy in making factual

determinations related to the Policy, its benefits, and the Insured; and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw or add benefits to, or terminate this Plan. Any termination of the Policy must be in accordance with Eligibility & Termination of this Policy. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

Policy Holder Eligibility - To be eligible to be enrolled You must:

- Meet any eligibility criteria specified by the Plan;
- Be under the age of 65 and not eligible for Medicare;
- Pay required premiums when due; and
- Complete and submit to the Plan such application or forms that the Plan may reasonably request.

Dependent Eligibility - To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

Be the lawful Spouse of the Policy Holder or be a child of the Policy Holder or the Policy Holder's Spouse including:

- Children up to age twenty-six (26) who are either the birth children of the Policy Holder or the Policy Holder's Spouse or legally adopted by or placed for adoption with the Policy Holder or Policy Holder's Spouse;
- Children up to age twenty-six (26) for whom the Policy Holder or the Policy Holder's Spouse is required to provide health care Coverage pursuant to a Qualified Medical Child Support Order;
- Children up to age twenty-six (26) for whom the Policy Holder or the Policy Holder's Spouse is the court-appointed legal guardian;
- Coverage will be extended for children age twenty-six (26) who meet the Eligibility requirements, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Policy Holder or the Policy Holder's Spouse for support and maintenance, provided that: the onset of such incapacity occurred before age twenty-six (26), proof of such incapacity is furnished to the Plan by the Insured upon enrollment of the Dependent child or at the onset of the Dependent child's incapacity prior to reaching the limiting age and annually thereafter;

Service Area – The Service Area includes all counties within the State of Arkansas.

Medical Underwriting - Eligibility for Coverage under this Policy is based on health-related factors, excluding genetic testing. An evaluation of the applicant's medical history will determine acceptance and final Premium for this Coverage.

- In order to determine acceptance the Plan will review the Medical Questionnaire information from the Application agreement.
- If minor clarification is needed the Plan will send an additional questionnaire and ask You to complete the form.
- If more detailed information is needed additional medical information may be requested from the Provider listed on the Application agreement Medical Questionnaire or additional information provided by You.
- If we have not received the information requested within thirty (30) days, the application will be deemed denied.

Persons Not Eligible to Enroll

- A person who fails to meet the eligibility requirements specified in this Policy shall not be eligible to enroll or continue enrollment with the Plan for Coverage under this Policy.

- A person whose Coverage was terminated due to a violation of a material provision of this Policy shall not be eligible to enroll with the Plan for Coverage under this Policy.

- A person who is on active duty in the armed forces of any country shall not be eligible to enroll.

- Except as otherwise specifically stated in the Policy or as required by law, initial enrollment is limited to individuals who are not eligible for Title XVIII of the Social Security Act 49 Stat. 620 (1935), 42 USCA 301 as amended (Medicare) or any similar program sponsored by the federal government or a state government.

  If you become eligible for Medicare while you are covered under this Policy, you should enroll for and maintain coverage under both Medicare Part A and Part B.

  When you reach age 65, we will assume that you have enrolled in Medicare Part A and Part B.

Special Enrollment Due to New Dependent Eligibility - Subject to the conditions set forth below, a new Dependent of the Policy Holder or the Policy Holder's Covered Spouse may enroll in the Plan if the Policy Holder or the Policy Holder's Covered Spouse has acquired a Dependent through marriage, birth, adoption or placement for adoption.

- New Spouse Due to Marriage. Subject to the Medical Underwriting provisions noted above, the Policy Holder's new Spouse may enroll at any time after marriage.

- New Dependents Due to Birth. A newborn child born to the Policy Holder or the Policy Holder's Covered Spouse may be Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first five (5) days from the date of birth or until the mother is discharged, whichever is earlier. For Coverage to continue beyond the first five (5) days, an Application agreement to enroll the newborn must be received within ninety (90) days from the date of birth, and subject to all eligibility requirements.

- New Dependents Due to Adoption. A child who becomes a Dependent as a result of adoption or placement for adoption, may enroll within sixty (60) days from the date of adoption or placement for adoption.

- If application to enroll the new Dependent is submitted beyond the time limits noted above, the application will be subject to the medical underwriting provisions.

Notwithstanding the above, a common law Spouse qualifies as a Spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.

Effective Date. Coverage shall become effective on the Effective Date indicated in the notification of acceptance the Plan sends You. You will receive such notification when the Plan receives a completed Application Form and approves the enrollment. You will not be enrolled until You receive such notice. Your payment of the applicable premium is considered to be your acceptance of Coverage.

Notification of Change in Status. You must notify the Plan of any changes in Your status within thirty (30) days of the event. Submit this notice to the Plan's Customer Service Department at [(800) 969-3343] or through the website at [www.chckansas.com]. Events qualifying as a change in status and requiring notice include, but are not limited to, change in name or address, and Medicare eligibility. We should be notified within a reasonable time of the death of the Insured.

Termination of Policy and Renewal This Policy shall be renewable at the option of the Insured, except as described immediately below. Non-renewal shall not be based upon the deterioration of mental or physical health of the Insured under this Policy.

Your Coverage shall terminate if any one of the following events occurs:

- **Loss of Eligibility.** If You no longer meet the eligibility requirements set forth in this Policy, Your coverage shall end at 11:59 p.m. on the date You no longer meet the eligibility requirements.

- **Rescission of Coverage.** Coverage for an Insured under this Policy may be canceled, Reformed or Rescinded based on medical or other enrollment or eligibility information received which was not properly or completely disclosed, or was falsely disclosed in Your Application agreement, prior to contracting or enrollment. NOTE: If an Insured's coverage is Rescinded, as described in this section, coverage will be termed back to the effective date and the Plan will seek recovery of all payments made on the Your behalf. Therefore, both the Plan and the Insured will be returned to a financial position as if no coverage had ever been in force. The Plan may initiate this action in the event that, among other possible reasons, there is a Material Misrepresentation that led the Plan to provide coverage. However, an Insured's coverage will not be Rescinded due to improper disclosure on the Application agreement after coverage has been in effect for two years. This exception does not apply in the case of fraudulent misrepresentation.

- **Non-payment of Premiums.** You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the ten (10) day grace period, you will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the ten (10) day grace period.

- **Change in Status.** In the event You change Your place of residence within Our Service Area, You will be offered an opportunity to enroll in a new Policy. [If you move outside Our Service Area you will be notified within thirty (30) days, of your Policy termination.]

- **Fraud.** You participate in fraudulent or criminal behavior, including but not limited to:

  √ Performing an act or practice that constitutes fraud or Material Misrepresentation of facts including, but not limited to using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled.

  √ Allowing any other person to use Your identification card to obtain services. If the Insured allows any other person to use his/her identification card to obtain services, the Coverage of the Insured will be terminated.

  √ Knowingly misrepresenting, omitting or giving false information on any Policy forms and medical questionnaire.

Premium Payment

Amount of Premium. The monthly premium due for Your coverage under this Policy is stated in the proposal page and may be updated as explained below.

Payment of Premium. The first premium payment(s) is due no later than ten (10) days after the effective date of Your Policy. (For example, Your policy begins July 1, Your premium is due by the 10th of July and must be paid by the 10th of each month.) Premium payments for subsequent months shall be due on the 10th day of each month.

All premium payments must be automatically deducted from either a checking or savings account of a banking institution. If funds are not available at the time of the automatic deduction, You will receive a notice that payment is due directly to Coventry Health & Life Insurance Company. The Plan may impose a service charge when payments are refused and/or returned by the Your financial institution, such as, but not limited to, an account with non-sufficient funds available. Payments should be sent to:

Coventry Health & Life Insurance Company

[P.O. Box 6512
Carol Stream, IL 60197-6512]

Grace Period. You are granted a Grace Period of ten (10) days to make payment of every premium due. This means that if Your premium is not paid on the date that it is due, You must pay it within the following ten (10) days. This Policy will remain in force during this Grace Period. If You do not pay Your total premium by the end of the Grace Period, Your coverage will be retroactively terminated to the date covered by Your last paid premium.

Changes in Premiums. The Plan reserves the right to change Premiums upon ten (10) days written notice to the Policyholder.

- We will automatically change the amount of Your Premium should a birthday place You into the next age classification upon which Premiums are based.
- We may also change the amount of Your Premiums, upon ten (10) days written notice if the Premiums of Your entire age classification are changed.

Effect of Termination.

If Your Coverage under this Policy is terminated, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination.

- Identification cards are the property of the Plan and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.
- Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Grievance and Complaint procedures. The Plan may not terminate the Policy solely for the purpose of effecting the disenrollment of the Insured for either of these reasons.
- If the Insured receives Covered Services after the termination of Coverage, the

Plan may recover the contracted charges for such Covered Services from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

Reinstatement of Coverage

If any renewal Premium is not paid within the time granted the Insured for payment, a subsequent acceptance of Premium by the Plan or by any agent duly authorized by the Plan to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Plan or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Policy will be reinstated upon approval of such application, by the Plan, or lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the Plan has previously notified the Insured in writing of its disapproval of such application.

The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the Insured and the Plan shall have the same rights there under as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date or reinstatement.

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the Policy, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued. If the Plan elects to discontinue offering all health insurance Coverage in the individual market, You will receive a written notice of discontinuation at least one hundred and eighty (180) days before the date the Coverage will be discontinued.

Certificates of Creditable Coverage.

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Pre-Certified, if Pre-Certification is required, (3) not expressly excluded in the list of Exclusions and Limitations section as set forth in this Policy, and (4) incurred while the Insured is eligible for Coverage under the Plan. It is the Insured's responsibility to verify whether a Covered Service requires Pre-Certification and should always reference the Schedule of Pre-Certification Requirements prior to receiving Covered Services. You should not assume that a Participating Provider has already accomplished the Pre-Certification.

The following section, **Schedule of Covered Services**, provides the services and supplies Covered under this Policy. The schedule is provided to assist You with determining the level of Coverage, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in this Policy. If a service is not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service.

Please note that the Covered Services in the schedule below are subject to all applicable Exclusions and Limitations of this Policy.

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Allergy	Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	**Exclusions:** See Exclusion Section relating to allergy services.
Ambulance (air and ground)	Coverage is provided for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency services can be rendered.	**Exclusions:** See Exclusion Section regarding ambulance services.
Blood and Blood Products Processing	Coverage is provided for administration, storage, and processing of blood and blood products in connection with services Covered under this Policy.	**Exclusions:** See Exclusion Section regarding blood and blood products.
Breast Reconstruction	Coverage is provided for breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy resulting from diagnosed cancer. As required by the Women's Health and Cancer Rights Act ("WHCRA"), if You elect breast reconstruction after a Covered mastectomy, benefits will be provided for (1) augmentation and reduction of the affected breast, (2) augmentation or reduction on the opposite breast to restore symmetry, (3) prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction.	**Exclusions:** See Exclusion Section regarding Reduction or Augmentation Mammoplasty.
Cardiac Rehabilitation Services	Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Chemotherapy	Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer.	**Limitations:** Chemotherapy benefit is subject to the Plan's Experimental and Investigational exclusion.
Colorectal Cancer Screening	Coverage is provided for a colorectal cancer exam and related laboratory testing for any asymptomatic Insured pursuant to the Plan's criteria, which are in accordance with the current American Cancer Society and U.S. Preventive Services Taskforce guidelines.	
Contraceptive Devices	Coverage is provided for contraceptive implants, diaphragms, and IUDs (including their insertion and removal), as specifically provided in the Schedule of Benefits. Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider.	
Dental Services	Coverage is provided for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if: (1) The provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and (2) The patient is: (A) A child under seven (7) years of age who is determined by two (2) dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; (B) A person with a diagnosed serious mental or physical condition; or (C) A person with a significant behavioral problem as determined by the Insured's physician. If a person is covered under both this Plan and a benefit plan that provides dental benefits, the health benefit plan that includes dental benefits is the primary payer.	Limited benefit. **Exclusions:** See Exclusions Section regarding dental services.
Dermatological Services	Coverage is provided for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Dialysis	Coverage is provided for hemodialysis and peritoneal services provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.	
Diabetic Supplies	Coverage includes Plan approved glucose meters and self-management training used in connection with the treatment of diabetes.	**Limitations:** Disposable insulin syringes, glucose strips, and lancets are Covered under the pharmacy Rider. If a pharmacy Rider is not purchased, Coverage for this benefit will be provided under this Policy.
Durable Medical Equipment ("DME")	Coverage is provided when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member. The wide variety of DME and continuing development of patient care equipment makes it impractical to provide a complete listing of Covered or non-Covered equipment here. Therefore, the Plan may approve requests on a case by case basis. The Plan may rent or purchase DME.	Upgrades to equipment are the responsibility of the Insured. **Exclusions:** See Exclusions Section regarding DME Coverage.
Emergency Services	Coverage is provided for health services and supplies furnished or required to screen and stabilize an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. The determination of Covered Services for services rendered in an emergency facility is based on the prudent layperson standard, along with those relevant symptoms and circumstances that preceded the provision of care. Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and Pre-Certification is not required.	You should notify Your Physician and the Plan within 48 hours of admission or the next business day or as soon as physically able.
Eye Glasses and Corrective Lenses	Not a Covered Service, except for the first pair of eyeglasses or corrective lenses following cataract surgery	**Exclusions:** See Exclusions Section regarding eyeglasses and contact lenses.
Genetic Counseling and Studies	Coverage is provided for genetic counseling and genetic studies only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities and the testing will alter the	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	outcome of treatment.	
Gynecological Examinations	Coverage is provided for routine well-woman examinations, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society and the U.S. Preventive Services Taskforce Guidelines.	
Hearing Screenings	Coverage is provided for a hearing screening to determine hearing loss.	
Home Health Care Services	Coverage is provided when all of the following requirements are met: (1) the service is ordered by a Physician; (2) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, respiratory therapist, or occupational therapist; (3) part-time intermittent services are required; (4) a treatment plan has been established and periodically reviewed by the ordering Physician; and (5) the agency rendering services is licensed by the State of location.	**Exclusions:** See Exclusions Section regarding Home Services.
Hospice	Coverage is provided for hospice care rendered by a Provider for treatment of a terminally ill Insured when ordered by a Physician. Care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the Illness, and guidance and assistance during the Illness for the purpose of preparing the Insured and the Insured's family for a terminal Illness.	
Inpatient Hospital Care	Coverage includes semi-private accommodations and associated professional and ancillary services. Certain services rendered during the Insured's Confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits and Schedule of Exclusions.	**Exclusions:** See Exclusions Section regarding Private inpatient room.
Laboratory and Pathology Services	Coverage is provided as listed in the Schedule of Benefits.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Newborn Care	The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, Reconstructive Surgery for the treatment of medically diagnosed congenital defects or birth abnormalities. Coverage is provided for all eligible newborns to be tested or screened for phenylketonuria ("PKU") and such other common metabolic or genetic diseases. Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.	.
Nutritional Counseling	Coverage is provided when provided by a registered dietician and when the Insured is diagnosed with diabetes.	
Oral Surgery and Diseases of the Mouth	Coverage includes only oral surgical services limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect. Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin.	**Exclusions:** See Exclusions Section regarding oral surgery and dental services.
Orthotic Devices	Coverage is provided for the initial purchase of Orthotic Appliances following the onset or initial diagnosis of the condition for which the device is required. Coverage is provided for Orthotic Appliances, splints and braces, including necessary adjustments to shoes to accommodate braces. Shoe inserts will be Covered only if the Insured has diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace.	**Exclusions:** See the Exclusions Section regarding Orthotic Appliances.
Osteoporosis	Coverage is provided for services related to diagnosis, including central bone density tests; medically necessary treatment and appropriate management of osteoporosis. In determining medical appropriateness, due consideration shall be given to peer-reviewed medical literature.	
Outpatient Diagnostic Services	Coverage is provided for services and supplies for outpatient diagnostic services provided under the direction of a Provider at a Hospital or Alternate Facility. Coverage for testing pregnant women and children for lead poisoning shall be covered as any	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	other outpatient diagnostic service. Also covered is human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing for A, B, and DR antigens.	
Outpatient Surgery	Coverage is provided for services and supplies for outpatient surgery provided under the direction of a Provider at a Hospital or Alternate Facility.	
Outpatient Therapy Services	Coverage is provided for short-term outpatient therapy services that are expected to result in significant functional improvement of the Insured's condition, limited to physical therapy, occupational therapy, and speech therapy. Speech therapy is covered for loss or impairment of speech or hearing. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and which fall within the scope of his/her license or certification.	**Exclusions:** See Exclusions Section.
PKU or any other Amino and Organic Acid Inherited Disease Formula/Food	Coverage is provided for formula and/or food used for PKU or any other amino and organic acid inherited disease that is recommended by a Provider as determined by the Plan to be Medically Necessary.	
Physician Services	Coverage is provided for Physician Services, including but not limited to, office visits, Hospital visits, consultations, and interpretation of tests.	
Preventive Services	The preventive health services referenced below shall be covered in full and are not subject to cost-sharing requirements (including co-payments, co-insurance and deductible), in a manner consistent with Section 2713 of Federal H.R. 3590. A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force; B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention ("ACIP - CDC"); C. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	D. Additional preventive care and screenings for women (including breast cancer screening and mammography screenings) not described in paragraph (A). A list of the preventive services covered under this paragraph is available on our website at [www.chckansas.com] or will be mailed to You upon request. You may request the list by calling the Customer Service number on Your identification card.	
Prosthetic Devices	Coverage is provided for the initial purchase of Prosthetic Devices following the onset or initial diagnosis of the condition for which the device is required. For Prosthetic Device placements requiring a temporary and then a permanent placement only one (1) temporary device will be Covered. Coverage is provided for Prosthetic Devices, including but not limited to, purchase of artificial limbs, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. Coverage is provided for external Prosthetic Devices that are used in lieu of surgery for breast reconstruction due to a mastectomy. Coverage will be provided for replacement of Prosthetic Devices, which become non-functional and non-repairable due to: (1) A change in the physiological condition of the Insured; (2) Irreparable wear or deterioration from day-to-day usage over time of the device; or (3) The condition of the device requires repairs and the cost of such repairs would be greater than the cost of a replacement device. Prosthetics will be replaced for documented growth in a child requiring replacement. Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.	Coverage for Prosthetic devices will be subject to the benefit limit as expressed in the Schedule of Benefits. Coverage for internal prosthetic devices, including but not limited to, artificial heart valves, artificial joint appliances, orthopedic implants, will not be subject to the benefit limit. **Exclusions:** See Exclusions Section regarding Prosthetic Devices.
Pulmonary Rehabilitation Services	Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.	
Radiation Therapy	Coverage is provided for standard radiation therapy.	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Radiology	Coverage is provided as determined by the Plan.	
Reconstructive Surgery	Services are limited to the surgical correction of congenital birth defects or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment.	**Limitations:** Coverage for reconstructive surgery for a congenital birth defect shall be Covered only for dependent children [through age eighteen (18)]. **Exclusions:** See Exclusions Section regarding Cosmetic Services and Surgery.
Rehabilitation Services and Supplies	Coverage is provided for short-term inpatient or outpatient rehabilitation services which are expected to result in significant functional improvement of the Insured's condition. Rehabilitation services must be performed by a Provider, including a free standing rehabilitation facility.	**Exclusions:** See Exclusions Section regarding rehabilitation services and supplies.
Sleep Studies	Covered Services.	**Exclusions:** See Exclusion Section regarding sleep studies.
Skilled Nursing Facility Services	Coverage is provided for Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of a Provider in a Skilled Nursing Facility. Services rendered in a Skilled Nursing Facility are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan.	**Limitations:** Coverage in a Skilled Nursing Facility may be subject to a Benefit Year limitation as specified in the Schedule of Benefits. Certain ancillary services rendered during the Insured's Confinement are subject to separate benefit restrictions and/or Insured responsibilities as described elsewhere in this Policy or in the Schedule of Benefits.
Spinal Manipulation Services	The following services are Covered when they are delivered by a duly licensed Provider acting within the scope of his or her license: • Initial Examinations Coverage includes the initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder. This examination is performed to determine the nature of the Insured's problem. Examinations should be limited to the portion of the body in which the symptoms are being experienced. A more thorough examination of the bodily systems	

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	may be done if appropriate clinical indications are present and documented. Vital signs should be included in examinations when appropriate. • Subsequent Office Visits This may include an adjustment, a brief examination and other Medically Necessary services. • Re-examination This is performed to assess the need to continue, extend, or change the course of treatment. A re-evaluation may be performed during a subsequent office visit.	
Sterilization (voluntary)	Covered Service.	**Exclusions:** See Exclusions Section regarding reversal of sterilization.
Therapeutic Injections and IV Infusions.	Coverage is provided for Injectable and Self-Injectable medications when FDA-approved, medically appropriate subject to the Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan.	**Limitations:** Certain Self-Injectable medications may be Covered by a pharmacy Rider and therefore excluded from the medical benefit. **Exclusions:** See Exclusions Section regarding Prescription medications.
Transplants	Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Coventry Transplant Network participating facility and the recipient is an Insured. Donor screening tests are Covered and when performed at a Coventry Transplant Network participating facility. If not Covered by any other source, the cost of any care, including complications up to 90-days, arising from an organ donation by a non-Insured when the recipient is an Insured will be Covered for the duration of the Policy. Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants.	**Exclusions:** See Exclusions Section regarding transplant services.

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	The cost of any care, including complications, arising from an organ donation by the Insured when the recipient is not an Insured is excluded. If the Insured resides more than one hundred-fifty (150) miles from the transplant facility, reimbursement for travel will be Covered. Travel expenses may include the lodging for one family member or responsible adult. Lifetime limitation for travel and lodging are determined by the Plan.	
Urgent Care Services	Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention. If possible, please contact Your Physician in the event Urgent Care services are/were rendered. Your Physician is available to provide guidance and direction in situations that may require Urgent Care. However, failure to notify Your Physician will not result in denial of Coverage. If Medically Necessary follow-up care related to the initial Urgent Care service is required, you should contact and coordinate with Your Physician.	
Vision Services	Coverage is provided for eye examination to include, if Medically Necessary, medical history; evaluation of visual acuity; external examination of the eye; binocular measure; ophthalmoscopic examination; medication for dilating pupils and desensitizing the eyes for tonometry; summary and findings, a determination as to the need for correction of visual acuity, prescribing lenses, if needed.	**Exclusions:** See exclusions section regarding Vision Services.

[Pre-Existing Conditions Limitation

Pre-Existing Conditions may affect Your premium rate, may result in denial of Your application, or We may deny Coverage for them for a period of time after Your effective date. If You are accepted for Coverage, Your premium rate will be calculated to include any Pre-Existing Condition that You disclosed on Your enrollment form, and such conditions will be Covered under the terms of Your Policy beginning on Your effective date. Any Pre-Existing Condition(s) that is not disclosed on Your enrollment form will be excluded from Coverage for a period not longer than twelve (12) months after Your effective date .

Pre-Existing Condition Exclusions shall not apply to any Covered Person under the age of 19.]

Non-Duplication of Coverage Under Certain Laws

Motor Vehicle Coverage

This Policy will always be secondary to any state no-fault law that requires motor vehicle liability policies to provide person injury protection insurance for the insured and any passengers. Individual automobile "no fault" medical payment contracts that provide personal injury protection or no-fault benefits in excess of the minimum limits required by state law will remain primary to the limit or extent of the personal injury protection benefit provided in the automobile insurance policy. The plan benefits will be reduced by the amount of the personal injury protection coverage paid for by any such no-fault law or limit provided in the applicable automobile insurance policy. If a vehicle insurance policy has a provision providing personal injury protection coverage, whether required by law or not, such coverage will be primary over coverage provided by this Policy. The Insured agrees to furnish information to the Plan concerning any applicable personal injury protection insurance upon request.

Right of Recovery

The Plan has the right to correct benefit payments that are made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payments if any underpayments have been made.

General Exclusions

Unless otherwise stated in this Policy, the following items are excluded from Coverage:

1) Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Policy;

2) Any service or supply that is not Medically Necessary;

3) Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service;

4) Any service or supply for which You have no financial liability or that was provided at no charge; those services for which the Insured has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Policy;

5) Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;

6) Court-ordered services or services that are a condition of probation or parole;

7) Those services otherwise Covered under the Policy, but rendered after the date Coverage under the Policy terminates, including services for medical conditions arising prior to the date individual Coverage under the Policy terminates; and

8) Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as the Insured, or rendered by a person who is a member of the Insured's family, including Spouse, brother, sister, parent, step-parent, child or step-child.

Specifically excluded services include, but are not limited to, the following:

1) **Acupuncture -** Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not Covered;

2) **Allergy Services -** Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;

3) **Alternative Therapies** - Alternative therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;

4) **Ambulance Service -** Non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Insured;

5) **Augmentative Communication Devices –** Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Insureds;

6) **Autopsy** - Those services and associated expenses related to the performance of autopsies, and also post-mortem genetic studies;

7) **Behavior modification;**

8) **Biofeedback;**

9) **Blood and Blood Products - The cost of whole blood and blood products replacement to a blood bank;**

10) **Blood Storage** - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;

11) **Braces and supports needed for athletic participation or employment;**

12) **Charges resulting from Your failure to appropriately cancel a scheduled appointment;**

13) **Cochlear Implants** and related services;

14) **Cosmetic Services and Surgery** - Those services, associated expenses, or complications resulting from Cosmetic Surgery, which alters appearance but does not restore or improve impaired physical function. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes;

15) **Counseling Services** and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;

16) **Custodial Care**, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists the Insured in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services;

17) **Dental Services -** Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the surgical treatment of temporomandibular joint disorder ("TMJ"), whether the services are considered to be medical or dental in nature except as provided in the "Covered Services" Section of this Policy. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). The diagnosis and treatment for TMJ and craniomandibular joint disease is not Covered unless by an attached Rider. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;

    Also excluded from coverage are dental services when such services are directly related to an accidental injury. This includes but is not limited to treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an accidental injury.

    Removal of teeth, including any prophylactic extractions, as a complication of radionecrosis is not a Covered Service

18) **Dental Surgery and Implants** - Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded.;

19) Medical services and expenses incurred for learning disabilities, **developmental delays**, mental retardation, and autistic disorders.

20) **Durable Medical Equipment ("DME")** - Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home blood pressure monitoring devices; home oximetry units; home traction units; replacement for changes due to obesity; preventive or routine maintenance due to normal wear and tear or negligence of items owned by the Insured; personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services;

21) **Educational Services** Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;

22) **Equipment** or services for use in altering air quality or temperature;

23) Educational testing or psychological testing, unless part of a treatment program for Covered Services;

24) **Elective or Voluntary Enhancement -** Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition,

service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan;

25) **Eligible Expenses** - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;

26) **Enteral Feeding Food Supplement** - The cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

27) **Examinations** - Unless otherwise Covered under the Covered Services Section, those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, travel, employment, insurance, marriage or adoption. Also excluded are services relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type;

28) **Exercise equipment**, hot tubs and pools;

29) **Eye Glasses and Contact Lenses** - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;

30) **Food or food supplements ,** regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease;

31) **Foot Care** – Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Insured;

32) **Foreign Travel -** care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services;

33) **Growth Hormone –** Growth hormone therapy for any condition, except in children less than 18 years of age who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan;

34) **Hair analysis, wigs and hair transplants -** Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Provider;

35) **Home services to help meet personal, family, or domestic needs;**

36) **Health and Athletic Club Membership** - Any costs of enrollment in a health, athletic or similar club;

37) **Hearing Services and Supplies** - Those services and associated expenses for hearing aids, cochlear implants, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests, unless Covered by an attached Hearing Aid Rider;

38) **Household Equipment and Fixtures** - Purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;

39) **Hypnotherapy and Hypnosis;**

40) **Immunizations** unless specifically covered under the Policy, including but not limited to immunizations required for travel, school, work-related, Anthrax vaccine and Lyme Disease vaccine. Also excluded are examinations and testing in connection with insurance, obtaining employment, specifically for the purpose of entering school, participating in extracurricular school activities, adoption, immigration and naturalization, or examinations or treatment ordered by a court or an employer; premarital blood testing;

41) **Infertility/Reproductive Services** - All diagnostic studies, non-diagnostic services, and certain surgical procedures that are related to diagnosing and/or treating Infertility. Also excluded are expenses incurred for the promotion of conception including, but not limited to, artificial insemination, intracytoplasmic sperm injection ("ICSI"), in vitro or in vivo fertilization, gamete intrafallopian transfer ("GIFT") procedures, zygote intrafallopian transfer ("ZIFT") procedures, embryo transport, egg harvesting (collection, storage, preparation), reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis (for example, determining sex) , other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered under the terms of the Policy; No legal obligation to pay - Services are excluded for Injuries and Illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health services and supplies furnished under or as part of a study, grant, or research program;

42) **Maternity Services** – Expenses incurred for any condition of or related to pregnancy, except complications arising from and unless specifically covered in the Schedule of Benefits. Also excluded are expenses associated with selective reduction during pregnancy.

43) **Maintenance Therapy** – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;

44) **Male Gynecomastia –** Those services and associated expenses for treatment of male gynecomastia.

45) **Massage Therapy – Those services and associated expenses related to massage therapy;**

46) **Medical complications** arising directly or indirectly from a non-Covered Service;

47) **Mental Health Services -** the diagnosis and treatment of all biologically based Mental Illnesses and psychiatric conditions, unless Covered by an attached Mental Health Substance Abuse Rider;

48) **Military Health Services** - Those services for treatment of military service-related disabilities when the Insured is legally entitled to other Coverage and for which facilities are reasonably available to the Insured; or those services for any Insured who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;

49) **Miscellaneous Service Charges** - Telephone consultations, document processing or copying fees, mailing costs, charges for completion of forms, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), any late payment charge, interest charges or other non-medical charges;

50) **Non-Prescription Drugs and Medications** - Over-the-counter ("OTC") drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

51) **Nutritional-based Therapy** - Nutritional-based therapies except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

52) **Newborn** home delivery and also the cost of child birth classes;

53) **Obesity Services** - Those services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature

54) **Occupational Injury** - Those services and associated expenses related to the treatment of an occupational Injury or Illness for which the Insured is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services under this Policy;

55) **Oral Surgery Supplies** - required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;

56) **Orthodontia** and related services;

57) **Orthotic Appliances, Repairs or Replacement** - The replacement costs for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated; also excluded are cranial (head) remodeling band for the treatment of postitional non-synostotic plagiocephaly; and other protective head gear;

56) **Over-the-counter supplies** such as ACE wraps, elastic supports, finger splints, Orthotics, and braces; also OTC products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

59) **Personal comfort and convenience** items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

60) **Prescription Drugs and Medications** - Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider.

61) **Private Duty Nursing** - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;

62) **Prosthetic Devices Repairs or Replacement** - The replacement costs for any otherwise Covered device, including replacement for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured;

62) **Private inpatient room**, unless Medically Necessary or if a Semi-private room is unavailable;

64) **Reduction or Augmentation Mammoplasty** - Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer;

65) **Reversal of Sterilization Services** - Those services and associated expenses related to reversal of voluntary sterilization;

66) **Sex Transformation Services** - Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;

67) **Sexual Dysfunction** - Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;

68) **Sleep Studies – Sleep studies provided within the home;**

69) **Smoking Cessation** - Those services and supplies for smoking cessation programs and treatment of nicotine addiction;

70) **Speech therapy** or voice training when prescribed for stuttering or hoarseness;

71) **Sports Related Services** - Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces and orthotics;

72) **Substance Abuse** diagnosis and treatment, unless Covered by an attached Mental Illness Substance Abuse Rider;

73) **Surrogate motherhood** services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of the Insured acting as a surrogate mother;

75) **Transplant Organ Removal** - Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not Covered under the Policy unless the recipient is the Insured and the donor's medical Coverage excludes reimbursement for organ harvesting;

76) **Transplant services**, screening tests, and any related conditions or complications related to organ donation when the Insured is donating organ or tissue to a person not Covered under the Policy;

77) **Transplant Services** and associated expenses involving temporary or permanent mechanical or animal organs;

78) **Travel Expenses** - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section;

79) **Treatment for disorders** relating to learning, motor skills and communication;

80) **Vision Aids, Associated Services** - Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;

81) **Vocational therapy**;

82) Health services resulting from **war or an act of war** when the Insured is outside of the continental United States; and

83) **Work hardening programs**.

Coordination of Benefits

This section describes how Benefits under this Policy will be coordinated with those of any other plan that provides Benefits to You.

The order of Benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the Benefits it pays, so that payment from all plans do not exceed 100% of the Plan's Allowable Expenses.

Definitions

A **Plan**, or "other plan" is any of those which provides Benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. In addition, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"Allowable Expense" means a health care service or expense including Deductibles and Copayments, that is Covered, at least in part by any of the Plans covering You or Your Covered Dependent. When a Plan provides benefits in the form of service (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not Covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are not the Plan's Allowable Expenses:

- If a Insured is Confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is otherwise a Covered benefit) is not an Allowable Expense.
- If a Insured is Covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If a Insured is Covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.
- The amount a benefit is reduced because a Insured does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

"Claim Determination Period" means a Benefit Year. However, it does not include any part of a year during which an Insured has no Coverage under the Plan, or before the date this COB provision or a similar provision takes effect.

"Closed Panel Plan" is a Plan that provides health benefits to Covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

"Joint Custody" If the specific terms of a court decree state that the parents shall share joint custody without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined below.

Order of Benefit Determination Rules

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

- The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
- A Plan that does not contain a COB provision that is consistent with this provision is always Primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical Coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type Coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.
- The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.
    - √ Non-Dependent or Dependent. The Plan that covers the Insured other than as a Dependent, for example as an employee, Insured, Subscriber or retiree is Primary and the Plan that covers the Insured as a Dependent is Secondary. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Insured as a Dependent; and Primary to the Plan covering the Insured as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Insured as an employee, Insured, Subscriber or retiree is Secondary and the other Plan is Primary.
    - √ Child Covered Under More Than One Plan. The order of benefits when a child is Covered by more than one Plan is:
        - The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
            - √ The parents are married;
            - √ The parents are not separated (whether or not they ever have been married); or
        - If both parents have the same birthday, the Plan that Covered either of the parents longer is Primary.
        - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
        - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care Coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
  - √ The Plan of the Custodial Parent;
  - √ The Plan of the spouse of the Custodial Parent;
  - √ The Plan of the non-custodial parent; and then
  - √ The Plan of the spouse of the non-custodial parent.

√ Active or inactive employee. The Plan that covers a Insured as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Insured is a dependent of a person Covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

√ Continuation coverage. If a Insured whose coverage is provided under a right of continuation provided by federal or state law also is Covered under another Plan, the Plan covering the Insured as an employee, Insured, Subscriber or retiree (or as that Insured's dependent) is Primary, and the continuation Coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

√ Longer or shorter length of coverage. The Plan that Covered the Insured as an employee, Insured, subscriber or retiree longer is Primary.

√ If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, the Plan will not pay more than the Plan would have paid had the Plan been Primary.

Effect On The Benefits of the Plan

- The Benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- The Benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision (whether or not claim is made) exceeds those Allowable Expenses in a claim determination period. In that case, the Benefits of this plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses. When the Benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

- Provide the Plan with information about other coverage and promptly notify the Plan of any coverage changes;
- Give the Plan the right to obtain information as needed from others to coordinate benefits;
- Return any excess amounts paid to you to the Plan if the Plan or Your Provider provides a credit or payment and later finds that the other Coverage should have been primary.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Agreement. If it does, the Plan may pay the amount to the organization that made the payment. The amount will then be treated as though it was a benefit paid under the Agreement. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payment made by the Plan, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the terms of the Agreement, the Plan may recover the excess payments from one (1) or more of:

- The persons it has paid; or
- For whom it has paid; or
- Insurance companies; or
- Other organizations.

Right of Reimbursement

In consideration of the coverage provided by this Policy, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - √ Providing any relevant information requested by Us,
  - √ Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - √ Responding to requests for information about any accident or injuries,
  - √ Making court appearances, and
  - √ Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;

- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

The Insured may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, the Insured or Authorized Representative may call or write the Plan to file a complaint or an appeal. We will consider all the facts and handle all complaints and appeals promptly and fairly.

Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this Policy.

Complaints

A complaint is an expression of dissatisfaction that may be resolved on an informal basis. Complaints may be expressed by telephone or in person and are handled by Our Customer Service Department. The Customer Service Department may involve one or more staff members of the Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.

Written Complaints will be acknowledged in writing by Plan within 5 working days after receipt of the Complaint. The Plan will conduct an investigation within 20 working days after receipt of the respective Complaint, unless the investigation cannot be completed within this time. If the investigation cannot be completed within the 20-day timeframe, the Insured will be notified in writing by the 20th working day of the specific reasons for the delay, and the investigation will be completed within 30 working days thereafter. The Insured will be notified of the resolution within five (5) working days after the investigation of the respective Complaint is completed. Within fifteen (15) working days after the investigation of the respective Complaint is completed, the person, if other than the Insured, who submitted the Complaint will be notified.

The address and telephone numbers for Complaints are:

Coventry Health & Life Insurance Company
P.O. Box 7109
London, KY 40742
Telephone: (800) 969-3343

Appeals

If the issue in dispute relates to an Adverse Benefit Determination and the Insured and/or the Authorized Representative are dissatisfied with resolution of the complaint or does not wish to first file a Complaint, he or she may file an Appeal. The Appeals must be made within 180 days of the Adverse Benefit Determination.

The address for the Appeals Department is:

Coventry Health & Life Insurance Company
Attn: Appeals Department
8320 Ward Parkway
Kansas City, MO 64114

You may ask Us to appoint a staff member to assist with the Appeal at any time during the process.

One level of internal Appeal is provided if You, or your Authorized Representative, disagree with an Adverse Benefit Determination. The Insured or Authorized Representative may file an Appeal by sending Us a letter describing the reason for the Appeal. For Appeals based in whole or in part on medical judgment, the Appeal Committee will include a Medical Director and/or a Physician designee who have no prior involvement in the case and who are not subordinates of the individual who rendered the Adverse Benefit Determination. If the Medical Director and/or Physician designee are not in the same or similar specialty of the case under review, the Committee will also consult a health care professional who has training and experience in that

field of medicine.

- Appeals are concluded as follows:

  √ Urgent Care Appeals –Urgent Care Appeals will be completed within 72 hours after receipt of the Appeal request. We will notify the Insured and/or Authorized Representatives verbally and provide a follow-up written notice within 24 hours after receipt of the Appeal request.

  √ Pre-service Appeals – Requests for Pre-service Appeals will be acknowledged by letter within 5 working days of receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 15 calendar days of receipt of the Appeal request; however, with the Insured's permission, We may delay the resolution of the Appeal for 30 calendar days if We have not received adequate information.

  √ Post-service Appeals – Requests for Post-service Appeals will be acknowledged by letter within 5 working days of receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 20 working days from the date of the request for a Appeal; however, with the Insured's permission, We may delay the resolution of the Appeal for 30 calendar days if We have not received adequate information.

The Insured will be notified of the resolution within five (5) working days after the investigation of the respective Appeal is completed. Within fifteen (15) working days after the investigation of the respective Appeal is completed, the person, if other than the Insured, who submitted the Appeal will be notified. Our written notification to the Insured or Authorized Representative will provide the reason for the decision. Our notice will give the Insured or Authorized Representative instructions on any additional Appeal Rights available.

Contact Information

You may contact your respective the Insurance Department at anytime by mail or telephone: Arkansas Department of Insurance, 1200 West Third Street, Little Rock, AR 72201, (501) 371 2600 or (800) 282-9134, and fax at (501) 371-2618, or via email at Insurance.Consumers@arkansas.gov.

General Provisions

Applicability

The provisions of this Policy shall apply to the Insured and all benefits and privileges shall be available to You .

Governing Law

This Policy is delivered and governed by the laws of the State of Arkansas for Arkansas residents.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of five (5) years after the time written proof of loss is required to be furnished.

You are encouraged to exhaust the Policy's Complaint and Grievance Procedures prior to pursuing legal action, (in a court or other government tribunal) as this may be the most expeditious and cost-effective method of resolving Your concerns.

Time Limit On Certain Defenses

After two years from the date of issue of this Policy no misstatements, except fraudulent misstatement, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

No claim for loss incurred or disability commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from Coverage by name or specific description effective on the date of loss has existed prior to the effective date of Coverage of this Policy.

Nontransferable

No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by the Plan under this Policy. Such right to health care service Coverage or other benefits is not transferable.

Relationship Among Parties Affected by this Policy

The relationship between the Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Plan, nor is the Plan or any employee of the Plan an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

You are not an agent or representative of the Plan, and shall not be liable for any acts or omissions of the Plan for the performance of services under this Policy.

Contractual Relationships

The Plan agrees to provide Coverage for services to the Insured, subject to the terms, conditions, exclusions and limitations of the Policy. This Policy is issued on the basis of the Insured's enrollment in the Plan, and the payment and the Plan's acceptance of the required Premium. The Plan has the right to increase Premium rates, provided the Insured is given thirty-one (31) days advance written notice.

Reservations and Alternatives

The Plan reserves the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein. The identity of the service providers and the nature of the services provided may be changed from time to time and without prior notice to or approval by the Insured. You must cooperate with those persons or entities in the performance of their responsibilities.

Severability

In the event that any provision of this Policy is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Policy, which shall continue in full force and effect in accordance with its remaining terms.

Entire Contract

No change in this Policy shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Policy and/or by Amendment to this Policy. Such Amendments will be incorporated into this Policy. Amendments to the Policy are effective upon thirty-one (31) days written notice to the Insured. No change will be made to the Policy unless made by an Amendment or a Rider that is issued by the Plan. No agent or representative has authority to change the Policy or to waive any of its provisions.

This Policy, including all matters incorporated, contains the entire agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained herein. This Policy, including the application agreement, and all endorsements, exhibits, addenda, or amendments, if any, supersedes all prior communications, representations, or agreements, either verbal or written, between the parties.

Waiver

The failure of the Plan or You to enforce any provision of this Policy shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Policy shall not be deemed or construed to be a waiver of such default.

Records

The Insured shall furnish the Plan with all medical information and proofs of previous Coverage that the Plan may reasonably require with regard to any matters pertaining to this Policy in the event the Plan is unable to obtain this information directly from the Provider or previous insurer.

By accepting Coverage under the Policy, the Insured, who has signed the application, authorizes and directs any person or institution that has provided services to the Insured, to furnish the Plan or any of the Plan's designees at any reasonable time, upon its request, relevant information and records or copies of records relating to the services provided to the Insured. The Plan agrees that such information and records will be considered confidential. The Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning services which are necessary to implement and administer the terms of the Policy or for appropriate medical review or quality assessment.

Examination of the Insured

In the event of a question or dispute concerning Coverage for services, the Plan may reasonably require that a Participating Provider acceptable to the Plan examine the Insured at the Plan's expense.

Payment of Claims

Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

Clerical Error

Clerical error shall not deprive any individual of Coverage under the Policy or create a right to additional benefits.

Workers' Compensation

The Coverage provided under this Policy does not substitute for and does not affect any requirements for Coverage by any Workers' Compensation Insurance law, occupational disease law or similar legislation.

Misrepresentation

Coventry Health Care of Kansas, Inc. will not provide coverage for any Insured who has knowingly concealed or misrepresented any material fact or circumstance relating to this Policy in connection with the presentation or settlement of a claim.

Conformity with Statutes

Any provision of this Policy which, on its Effective Date, is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes and regulations.

Non-Discrimination

In compliance with state and federal law, the Plan shall not discriminate on the basis of age, color, disability, gender, marital status, national origin, religion, sexual preference, or public assistance status.

Cancellation By Insured

The Insured may cancel this Policy at any time by written notice delivered or mailed to the Plan, effective upon receipt of such notice or on such late date as may be specified in such notice. In the event of cancellation or death of the Insured, the Plan will promptly return the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Important Numbers & Addresses

Customer Service / Claims Coventry Health & Life Insurance Company Customer Service PO Box 7109 London, KY 40742 (800) 969-3343 (866) 285-1864 TDD http://www.chckansas.com/	**Pre-Certification** Coventry Health & Life Insurance Company 8320 Ward Parkway Kansas City, MO 64114 (877) 837-8914
Appeals and Grievance Coventry Health & Life Insurance Company Attn: Appeals Department 8320 Ward Parkway Kansas City, MO 64114	**Arkansas Department of Insurance** 1200 West Third St Little Rock, AR 72201 (800) 282-9134 Insurance.Consumers@arkansas.gov

CoventryOne. Underwritten by Coventry Health and Life Company and administered by [Coventry Health Care of Kansas, Inc.]	**PPO Schedule of Benefits** **[Plan Name]** **State(s) of Issue:** Arkansas	
Benefit	**Insured Responsibility**	
	Participating Providers	**Non-Participating Providers[2]**
[Policy Deductible[4] ([per Calendar Year] [per Contract Year] [Benefit Year]	[Individual:] [$0 - $15,000] [Family:] [$0 - $45,000]	[Individual:] [$0 - $30,000] [Family:] [$0 - $60,000]
[Coinsurance] [and] [Copayment] For All Eligible Expenses (unless otherwise noted)	[$0-$200] [Copayment] [and] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [0%-70%] [Coinsurance] [AD[3]]
[Coinsurance] [Out-of-Pocket[4]] Maximum [(per [Calendar Year] [Contract Year] [Benefit Year])]	Individual: [$0 - $30,000] Family: [$0 - $60,000]	Individual: [$0 - $30,000] Family: [$0 - $60,000]
Physician Office Services[1]		
▪ Primary Care Physician Office Visit[1]	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ Specialist Physician Office Visit[1]	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ X-ray & Laboratory Services	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ Allergy Injections	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ All Other Covered Services - Including but not limited to: Allergy Testing, Therapeutic Injections, Office Surgery	[Same as Physician Office Visit[1]] [$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[Same as Physician Office Visit[1]] [$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Preventive Care		
▪ Preventive Care – Including all Preventive Services described in the Covered Services Section of the CoventryOne Policy.	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ Immunizations-Adult	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]

▪ Immunizations-Pediatric (Up to age 72 months)	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ Mammogram [Diagnostic] [and] Routine Screening	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ Colonoscopy [Diagnostic] [and] Routine Screening	$0 Copayment	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Outpatient Laboratory Services		
▪ In a Physician's Office	[Same as Physician Office Visit[1]] [$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[Same as Physician Office Visit[1]] [$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ At a Free Standing Facility	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ At a Hospital Facility	[$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Outpatient Services At Hospital or Free Standing Facility		
▪ Radiology	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ Diagnostic Services	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
▪ Dialysis	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]]*

▪ Surgery and Scopes	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year']*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Inpatient Hospital Care		
▪ Inpatient hospital care, including semi-private room & board, intensive/coronary care, [maternity care,] x-ray, laboratory, professional services and other facility & ancillary charges.	[$0-$2,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-4,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
▪ Inpatient Rehabilitation *[Limited to [10 – 200] days per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-4,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Urgent Care and Emergency Care Services		
▪ Ambulance/Emergency Transportation (Ground or Air)	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*

▪ At an Urgent Care Center	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
▪ At a Hospital Emergency Room [(Copayment waived if admitted)]	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
▪ [Emergency Room] [Related Professional Fees]	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Short Term Therapies		
▪ Physical Therapy, Occupational Therapy & Speech Therapy *[Limited to [10 – 200] visits [per Therapy] per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
▪ Cardiac and Pulmonary Rehabilitation *[Limited to [10 – 200] visits per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*

▪ Partial Day Programs (4 hours or greater) *[Limited to [10 – 200] Visits per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
▪ Chiropractic Services/Spinal Manipulation *[Limited to [4 – 200] Visits per [Calendar Year] [Contract Year] [Benefit Year]]*	[Same as Specialist Physician Office Visit] [$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[Same as Specialist Physician Office Visit] [$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Other Services		
[Eye Exam] [including refraction] *[Refraction Services Limited to [1 – 6] exams every [12 – 48] Months]*	[Same as Physician Office Visit[1]] [$0-$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]]	[Same as Physician Office Visit[1]] [$0-$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]]
Injectable Medications (Not listed elsewhere)	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Skilled Nursing Facility *[Limited to [10 – 200] days per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [Per Admission] [Per Day] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*

Home Health Care *[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Hospice ▪ [Inpatient] *[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]* ▪ [Outpatient] *[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Durable Medical Equipment ▪ The cost of Phenylketonuria (PKU) or any other Amino and Organic Acid Inherited Disease Food when the food and food products exceeds the income tax credit of $2,400.	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Prosthetics & Braces	[$0-$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*	[$0-$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]*
Organ / Tissue Transplant *[Services provided at approved Coventry Transplant Centers] [only]*	See Appropriate Benefit	[$0-$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD[3]] [*Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]* *[Not a Covered Benefit]*

Please Note: Maximum Benefit Limits do not guarantee that all services will be approved to the Maximum number allowed under this plan. Coinsurance is based on the contracted allowed amount reimbursed to the provider, if applicable.

In order to receive the maximum benefits, it is Your obligation to ensure that any required Pre-Certification has been obtained. Please see the Pre-Certification requirements outlined in your Certificate of Coverage. [***Failure to do so may result in a [10 - 50%] reduction in benefits [,up to a maximum of [$100 – 500],] for that particular service.]***

1. Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP benefit will apply. If you receive this service from a Specialist, your Specialist benefit will apply.

2. When receiving services from non-participating providers, payment for Covered Services is limited to the lesser of the billed charge or the Out-of-Network rate less applicable Copayment, Coinsurance and/or Deductibles. Please refer to the Certificate of Coverage for additional details.

3. [AD means After Deductible. The [coinsurance] [and] [copayment] requirement applies after You have satisfied the Deductible requirement.]

4. [If you have individual-only coverage, you must satisfy the individual deductible and/or out of pocket maximum before any benefits will be paid. If two or more family members are on the same policy, you must satisfy the entire family deductible and/or out of pocket maximum before any benefits will be paid.]